

# Inquiry into the status of CFS / M.E. and research into causes and treatment



November 2006

Group on Scientific Research  
into Myalgic Encephalomyelitis  
(M.E.)

This Report was produced by the

[The Group on Scientific Research into Myalgic Encephalomyelitis \(ME\)](#)

Dr Ian Gibson MP (Chair)

Dr Richard Taylor MP (Vice-Chair)

Ms Ann Cryer MP (Secretary)

Rt Hon Michael Meacher MP

Dr Des Turner MP

Mr David Taylor MP

Lord Turnberg

The Countess of Mar

Baroness Cumberlege

Thanks go to the 'ME Community' for their submissions and patience. And thanks to our support staff, Ian Woodcroft, Huyen Le, Tom Davis, Sonia Wood and Sarah Vero who each stepped into the breach voluntarily and with such efficiency and goodwill at various time throughout the Inquiry.

## Foreword

This inquiry was set up following discussions with constituents towards the end of 2005. There were clearly strong views about the condition known to some as ME (Myalgic Encephalomyelitis) and others as CFS/ME (Chronic Fatigue Syndrome). Current recommended treatments, identification and referral leave much to be desired. For some sufferers, their personal physical experience of the illness has led to resentment of those who favour a psychosocial/ behavioural cause.

The Inquiry held five oral hearings details of each hearing are available by accessing the web-site, [www.erythos.com/gibsonenquiry](http://www.erythos.com/gibsonenquiry) . As we carried out the enquiry without any official funding or support, I am extremely grateful to those who have given their advice, time and financial support to the setting up and maintenance of the website. There are voices critical of these recordings and the nature and progression of the inquiry itself, but in defence, it must be acknowledged that whilst we aimed high, a lack of financial resources and a small central staffing hiatus midway through the inquiry meant that our scope was somewhat restricted.

Besides the hearings, we have had copious and comprehensive evidence in the form of documents, letters and CD's from major researchers in the field. The public also responded magnificently with verbal and written accounts of their experiences. There is undoubtedly a huge interest in this illness. I have attended various meetings to speak, listen and consult. I hope that this report, which follows on from the Chief Medical Officer's Working Group Report on CFS/ME published in 2002, will spark interest and action in many areas, particularly in government.

We have divided the report into different sections and, while there can be no guarantee that we included everything, the committee has reviewed the evidence and is determined to see action taken! We are left in no doubt that this is a contentious field and some of the evidence we heard provoked considerable hostility from the audience. Ours is a determined effort to bridge a huge gap in the knowledge and understanding of an illness that may involve 200,000 or more individuals.

It was with sadness that we recorded the death of a person suffering from ME/CFS whilst the hearings were in progress. We express our condolences to her family.

**Dr Ian Gibson MP, Chair of Committee**

# CONTENTS

The Group	Page	1
Foreword		2
Contents		3
1. Introduction	Page	5
1.1 What is CFS/ME?		5
1.2 Why is this report necessary?		6
1.3 The Extent of the Problem		6
1.4 The Cost		6
1.5 Central Issues		7
2. Defining the Condition	Page	9
2.1 Separate illnesses or a Spectrum of illness?		9
2.2 ME Sufferers Bill 1988		9
2.3 WHO Definition		9
2.4 ME in Teenagers and Children		10
2.5 The Current Approach in the UK		11
2.5.1 Kumar and Clark		11
2.5.2 Oxford Definition		11
2.6 Other Definitions		12
2.6.1 The Centre for Disease Control and Prevention		12
2.6.2 The Canadian Clinical Definition		13
3. The Science: Symptoms and Potential Causes	Page	18
3.1 The Oral Hearings		18
3.2 Other Evidence We Received	19	
3.3 Potential Causes		21
3.3.1 Lyme Borreliosis		21
3.3.2 Viruses		22
3.3.3 Organophosphates		22
3.3.4 Vaccination		22
4. Treatment	Page	23
4.1 Treating the Unknown		23
4.2 Existing Treatments		23
4.3 CBT		23
4.4 GET		23
4.5 Pacing		24
4.6 A Holistic Approach		24

4.7 Other Treatments	25
4.7.1 Pharmacological	25
4.7.2 Diet and Supplementary	25
4.7.3 Complementary & Alternative Therapies	25
4.7.4 Unorthodox Therapies	25
5. Government Provision: Service Structure & Research	Page 27
5.1 Treatment Centres	27
5.2 Research Issues	27
6. Benefit Entitlement	Page 29
6.1 Patients Experiences	29
6.2 What the Government Says	29
6.3 How the Dept. for Work & Pensions formulates policy	30
7. Conclusions	Page 31
7.1 The Groups Response	31
7.2 Areas for Further Examination	32
7.3 The immediate Future	34

## 1.0 Introduction

### 1.1 What is CFS/ME?

#### ME: Myalgic Encephalomyelitis

- Myalgic: **Myalgia** means pain in a muscle or group of muscles.
- Encephalomyelitis: **'Encephalo-'** refers to the brain; **'-myel-'** to the spinal cord and **'-itis'** denotes inflammation.<sup>1</sup>

#### CFS: Chronic Fatigue Syndrome

- **Chronic:** Persisting over a long period of time
- **Fatigue:** The state of weariness following a period of exertion, mental or physical, characterized by a decreased capacity for work and reduced efficiency to respond to stimuli.
- **Syndrome:** the association of several clinically recognizable features, signs, symptoms, phenomena or characteristics which often occur together and when taken as a whole define a condition.

ME was the term originally given to this illness in the 1950s. Some assert that the pathology of the term ME as given above is inaccurate. Their view is that there is not enough research evidence available to draw conclusions on whether there is widespread inflammation of the brain and spinal chord in ME sufferers. This led to the more general term CFS also becoming prevalent in the late 1980s. However, others feel Chronic Fatigue syndrome is not a suitable alternative term because of the absence of pathology in the title and because fatigue can occur as a symptom in many other illnesses.

There have been suggestions for renaming the disease according to its known pathology, notably the American terms Neuroendocrine Immune Dysfunction Syndrome (NIDS) Chronic Neuroendocrineimmune Dysfunction Syndrome (CNDS). This pathology refers to a brainhormone (neuroendocrine) and immune system dysfunction which is a syndrome i.e. collection of signs and symptoms that when taken as a whole defines the condition. **However until there is more evidence about the specific pathology of the illness it is of little use to consider alternative names.**

**The Group feels the condition deserves a name that reflects its pathology** but in view of the contentions surrounding it, it is probably wise not to be over restrictive hence we have used the term CFS/ME. We have used this term as it is the recognised term in the UK. It does not reflect the groups' opinion on what the name should be.

---

<sup>1</sup> Dowsett, E., G. (2004): *A Rose By Any Other Name*, available from [www.25megroup.org](http://www.25megroup.org) 5

## 1.2 Why is this report necessary?

CFS/ME is one of the most contentious illnesses in modern medicine. Due to a lack of knowledge of and research into the illness in the UK it exists somewhere between the schools of psychology and neurology. At present the only treatments are symptomatic and psychosocial. For the extremely affected sufferer this is not satisfactory. Nor is the current state of affairs satisfactory to this Group.

The Chief Medical Officers Working Group Report on CFS/ME (CMO Report) was published in 2002 and many hoped it would signal a landmark change in the perception and treatment of CFS/ME in this country. It identified a number of areas for improvement and made a number of recommendations. The Government has since ring fenced £8.5 million for CFS/ME treatment centres with a commitment to continue allocated funding after 2007.

However some of the CMO Report's recommendations for further research have been ignored. This is most apparent from the recent NICE draft guideline, which makes recommendations for research into the existing treatments, but does not mention the possibility of organic causes. The NICE guideline recommends treatments for which only controlled trial evidence is available at present but as we discuss later does not leave open the prospect that further research might lead to alternative therapies.

Our task is to highlight the ongoing struggle of the CFS/ME community and to ensure that the voice of the patient is heard. We have examined the available evidence, as far as we can in the time available to us.

## 1.3 The Extent of the Problem

It was estimated by the Chief Medical Officer's Report in 2002 that there could be anything from 100,000 to 250,000 people suffering from CFS/ME in the UK. However in their draft guidelines NICE states that there is limited epidemiological data of the number of sufferers in the UK and estimates are extrapolated from other countries.

It is extremely difficult to estimate the number affected by CFS/ME because of our lack of knowledge. The cause or causes are unknown. As such, there is no effective method of diagnosis, treatment or cure.

We do know that the £8.5 million ring fenced by the Department of Health for treating CFS/ME has been used to establish 13 treatment centres nationally. These new services expect to see 21,000 patients annually when working at full capacity.<sup>2</sup>

## 1.4 The Cost

The £8.5 million is only the tip of the iceberg in terms of the cost to the NHS. We know from testimonials that many patients are not diagnosed or mis-diagnosed. They then receive drugs and therapies not suitable to treat CFS/ME. As with many diseases, money invested in discovering the causes and potential treatments now, could save money in the long term.

The Medical Research Council (MRC) has invested over £11 million in research into ME/CFS but these have focused on the psychosocial aspects of the disease and in particular on controlled trials of treatments of this aspect of the illness. No

---

<sup>2</sup> Lord Warner The Minister of State, Department of Health speaking in Lords Hansard 29 Mar 2006 : Column WA114

major biomedical research projects funded by the MRC have been brought to our notice.

In 2003 Action for ME indicated that CFS/ME may be costing the UK £3.5 billion<sup>3</sup> annually in medical services, social benefits and lost incomes. The Centre for Disease Control and Prevention in the United States has estimated the cost to the US economy to be \$9.1 billion in lost productivity on top of medical costs and disability payments. They also estimated that the average American family affected by CFS loses \$20,000 a year in wages and earnings<sup>4</sup>.

## 1.5 Central Issues

Because CFS/ME is difficult to categorise, to diagnose and often impossible to treat, it has been a rich battleground for disagreement – even the name has proven contentious. Quite apart from the often strongly polarised views of some patient campaigning groups and the scepticism of some of the medical profession there have been disagreements even amongst those who represent different groups of patients and medical professionals. This has left many patients feeling very aggrieved and many doctors feeling misrepresented.

The Group believe that physical aspects have received less attention or support than they deserve and that this shortcoming must be addressed.

Despite this difficult background, a number of facts stand out on which most, if not all, agree:

- 1) CFS/ME can be a severe incapacitating illness and those who suffer from it may have their lives completely ruined. Carers and families are equally affected. We refer to our first session to the paraphrased minutes of the meeting.
- 2) Although there are many theories as to its cause or causes, none have been proven beyond reasonable doubt (see later for most plausible causes).
- 3) Research has been undertaken which offered tantalising glimpses of abnormalities in sufferers but thus far no specific causal factor has been established.
- 4) No single treatment has been shown to offer a cure despite the claims of individual cases. However, as the minutes show, some practitioners do believe they have achieved success in some cases.<sup>5</sup>
- 5) Although there is a strong resistance to the idea that CFS/ME is a “mental” illness, some patients become depressed as a result of their illness and sometimes treatment of this depression is helpful for at least that part of their illness.

---

<sup>3</sup> Action for ME ‘Cost to the Nation Report’ 2003 <http://www.afme.org.uk/news.asp?newsid=20>

<sup>4</sup> CDC CFS Toolkit: Fact Sheets for Healthcare Professionals Overview  
<http://www.cdc.gov/cfs/toolkit.htm>

<sup>5</sup> Gibson Inquiry Oral Hearings <http://www.erythos.com/gibsonenquiry/Hearings.html>



- 6) In the absence of known causes or cures patients require considerable care, compassion, understanding and support and, in particular, acceptance that they have a genuine and serious illness. Dismissal of symptoms is unhelpful and only encourages strong and counterproductive antagonisms between some patients and some doctors. The NICE (National Institute for Health and Clinical Excellence) guidelines indicate they are starting to introduce a more patient centred approach.
- 7) More research into possible causes and treatments is vital. We will elaborate on this and on how to improve the role of government and the funding bodies in new approaches.

## 2.0 Defining The Condition

### 2.1 Separate illnesses or a Spectrum of illness?

Several definitions of the disease exist but there is no agreement about which of these is likely to be most reliable. Some groups believe that only those with the most severe form of the disease really have authentic CFS/ME and that this represents a distinct disease category. This is because severe CFS/ME may have more symptoms and is less likely to respond to the existing treatments. They believe that the true sufferers of the disease are separate and distinct from those with less severe symptoms. In his presentation to the Group Dr Vance Spence provided a pie chart, which he said showed an extremely small number of chronic fatigue patients actually have ME, the rest having a variety of other already recognised illnesses. Others believe that there is a spectrum of disease from those with moderately severe symptoms to those gravely incapacitated. In the absence of a specific diagnostic test, there is no reliable way to determine which of these views is correct. What seems beyond doubt is that all these patients are suffering and need the best treatment available. A number of problems have arisen because of this definitional difficulty. It is unlikely the problem will be resolved unless and until a specific test or tests become available. **Government should fund more research into potential causes, which might lead to better diagnostic tests, and invite applications. Investigating potential sub-groups must be a strong priority.**

### 2.2 ME Sufferers Bill 1988

In the course of our investigations, we were made aware of research that has been done internationally. In Britain, there has been a clear historical bias towards research into the psychosocial explanations of CFS/ME. This is despite Parliament recognising ME as a physical illness in a Private Members Bill, the ME Sufferers Bill, in 1988.

### 2.3 WHO Definition

There is commonly held belief circulating that the World Health Organisation (WHO) categorises CFS/ME under both neurology (i.e. disorders of the nervous system) and neurasthenia (mental and behavioural disorders or other neurotic disorders<sup>6</sup>). Indeed this is reported in medical textbooks. The Group found this assertion to be incorrect. Confusion may have been caused by the ICD-10 only being partly available online.

The International Classification of Diseases (ICD-10) document produced by The WHO characterises Post-viral Fatigue Syndrome (PVS) and ME under Section G 'Diseases of the Nervous System.'

#### **"G93.3 Postviral fatigue syndrome**

Benign myalgic encephalomyelitis "<sup>7</sup>

---

<sup>6</sup>WHO ICD-10 Section F Mental and Behavioural Disorders F48 Other Neurotic Disorders  
<http://www.who.int/classifications/apps/icd/icd10online/>

<sup>7</sup> <http://www.who.int/classifications/apps/icd/icd10online/>

Andre L'Hours of the WHO Head Office confirmed this definition formally in writing in 2001 and again in 2004 to Lord Warner. The Group was concerned to find that there is no mention of this classification in the Chief Medical Officers Report 2002 or in the current NICE guidelines.

CFS is currently not present under any code in the ICD-10 on the WHO website current Tabular version. However, it is in the current Index version, according to the WHO North American Collaborating Center representative, who stated via email in September 2006 that "Chronic fatigue syndrome is indexed in the following manner in ICD-10:

Syndrome

- fatigue F48.0

--- chronic G93.3

--- postviral G93.3"<sup>8</sup>

The ICD-10 categorises Lethargy and Tiredness under section R "Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified" specifically under R53 'Chronic Malaise and Fatigue'. It specifically excludes ME and PVS (G93.3) and fatigue syndrome (48.0) from this definition.

The ICD-10 lists Fatigue syndromes under Section F48.0 Neurasthenia, but this section explicitly excludes ME and PVS (G93.3) or Malaise and Fatigue (R53).

The WHO in Geneva holds an internationally recognised classification that ME is a neurological disease. The Group feels that these definitional difficulties have only served to confuse the picture and will not be resolved unless further research is done to clarify the nature of the disease.

## 2.4 ME in Teenagers and Children

We included this section because it was previously thought that children could not have CFS/ME. The Group received numerous submissions from parents whose children had or were suspected to have CFS/ME. It has been thought that children could not suffer from CFS/ME but the Group accepts that CFS/ME is prevalent amongst teenagers and possibly in children. However it is very unlikely to occur in infants and young children and so should not be confused with Munchausen by proxy for example. In the absence of a recognised test, CFS/ME may be more readily open to misdiagnosis in older children and teenagers than other illnesses and doctors must be more aware of the pitfalls of failure to recognise the condition. We were concerned to receive written submissions from parents of children with CFS/ME who reported they were disbelieved by social services and community practitioners with the result that their children were put on the at risk register or even made wards of court and removed from the family home.

---

<sup>8</sup>Email from URC secretariat at WHO North American Collaborating Centre Tuesday September 26<sup>th</sup> 2006 available at <http://www.co-cure.org/hmc100306.htm#4>

## 2.5 The Situation in the UK

### 2.5.1 Kumar and Clark Endorsed by the BMA

At present, the British Medical Association endorses Kumar and Clark's "Clinical Medicine Fifth Edition" and "Clinical Medicine Sixth Edition". We have chosen this book as case study of existing medical practise in CFS/ME cases. These texts consider ME and CFS to be one illness. They also state that the term ME is declining in use because it "implies a pathology for which there is no evidence"<sup>9</sup>. It suggests that CFS is the correct term to use and that it is associated with "Perfectionist, obsessional and introspective personality traits, childhood trauma (physical and sexual abuse)." In the text's defence it does have limited space for each illness and does accept that there is "good evidence for the syndrome". Yet it only discusses the illness in the section on psychological medicine. In the fifth Edition it does list Post Viral/CFS Under "Infectious Diseases" however it immediately directs the reader to also see the Psychiatric Section and suggests "two thirds of patients with a symptom duration of more than six months may have an underlying psychiatric disorder". The fifth and sixth editions both state there is confusion surrounding the World Health Organisation definition. While CFS/ME remains only in the Psychological section of medical discourse, there can be little chance of progress. The Group was interested by the concept of a "biopsychosocial" model of illness as long as one aspect is not given particular prevalence over the other, both approaches must be considered at the same time.

### 2.5.2 The Oxford Criteria

The Oxford Criteria first published in 1991 are those generally used in the UK to diagnose persons with CFS/ME for research purposes. However due to the general nature of this guideline it is possible that patients with a spectrum of fatigue symptoms who are unlikely to have authentic CFS/ME will be included in research. The criteria are shown below.

#### "Chronic fatigue syndrome (CFS)

- a) A syndrome characterized by fatigue as the principal symptom.
- b) A syndrome of definite onset that is not life long.
- c) The fatigue is severe, disabling, and affects physical and mental functioning.
- d) The symptom of fatigue should have been present for a minimum of 6 months during which it was present for more than 50% of the time.
- e) Other symptoms may be present, particularly myalgia, mood and sleep disturbance.
- f) Certain patients should be excluded from the definition. They include:
  - ~ Patients with established medical conditions known to produce chronic fatigue (eg severe anaemia). Such patients should be excluded whether the medical condition is diagnosed at presentation or only subsequently. All patients should have a history and physical examination performed by a competent physician.
  - (i) Patients with a current diagnosis of schizophrenia, manic depressive illness, substance abuse, eating disorder or proven organic brain disease. Other

---

<sup>9</sup> *Kumar and Clark Clinical Medicine Fifth Edition*, edited by Parveen Kumar and Michael Clark, Saunders (Elsevier Ltd) Publishing 2004 p 1234

psychiatric disorders (including depressive illness, anxiety disorders, and hyperventilation syndrome) are not necessarily reasons for exclusion.

### Post-infectious fatigue syndrome (PIFS)

This is a subtype of CFS which either follows an infection or is associated with a current infection (although whether such associated infection is of aetiological significance is a topic for research). To meet research criteria for PIFS patients must

- (i) fulfil criteria for CFS as defined above, and
- (ii) should also fulfil the following additional criteria:

- a) There is definite evidence of infection at onset or presentation (a patient's self-report is unlikely to be sufficiently reliable).
- b) The syndrome is present for a minimum of 6 months after onset of infection.
- c) The infection has been corroborated by laboratory evidence.

In reporting studies it should be clearly stated which of these two syndromes is being studied. The degree of disability should be measured and stated. The criteria and method used to exclude subjects from study must be clearly described and the degree of examination and investigation specified. All patients should be assessed for associated psychiatric disorder and the results of this assessment reported.”<sup>10</sup>

The Group found that the international criteria paid far greater attention to the symptoms of CFS/ME while the Oxford Criteria focus very little on any symptoms other than long term tiredness. There is concern that the broad spectrum of patients who may be included in these criteria may lead to inaccurate results in patient studies of CFS/ME. The Group feels that there is room for a further review of the criteria which should be updated, in light of the peer reviewed and evidence based research done both internationally and in the UK in the past 15 years.

## **2.6 Other Criteria**

The Group received notice of a number of other criteria used for assessing whether a patient has CFS/ME.

### **2.6.1 The CDC CFS Toolkit**

The Group found the Centre for Disease Control and Prevention in the United States provided very interesting criteria in the form of their ‘CFS Toolkit’. The toolkit is described as “an easy to use resource for clinical care”<sup>11</sup>. It includes the following sections:

- CFS Overview
- Diagnosing CFS
- Managing symptoms
- Managing Supportive Care
- Cognitive Behavioural Therapy
- Managing Activity

---

<sup>10</sup> Journal of the Royal Society of Medicine Volume 84 February 1991 118-121 A report - chronic fatigue syndrome: guidelines for research

<sup>11</sup> Toolkit: Fact Sheets for Healthcare Professionals <http://www.cdc.gov/cfs/toolkit.htm>

- Provider Resource Guide

The CDC provides very patient focused criteria. It highlights the importance of recognising the condition and the serious nature of the condition in order to validate the patient's experience of the illness. It then advocates working with the patient and being flexible with treatment to see what works for the individual via tailoring a "multidimensional treatment program"<sup>12</sup>. It is an extremely useful resource for anyone involved in the clinical treatment of CFS/ME.

### **2.6.2 The Canadian Clinical Criteria**

In Canada, Dr Bruce Carruthers and his research team have developed a Diagnostic Protocol for CFS/ME. The Group found that these criteria were much more detailed, including many more symptoms of CFS/ME compared with the Oxford Criteria. Their exclusions are useful as they begin to extrapolate an idea of CFS/ME separate from other related or similar illnesses. As such, we have determined to reproduce the Carruthers table below:

---

<sup>12</sup> CFS Toolkit -CFS Overview - <http://www.cdc.gov/cfs/toolkit.htm>

## **DIAGNOSTIC PROTOCOL**

Although it is unlikely that a single disease model will account for every case of ME/CFS, there are common clusters of symptoms that allows a clinical diagnosis.

### ***Clinical Working Case Definition of ME/CFS***

<p><i>A patient with ME/CFS will meet the criteria for fatigue, post-exertional malaise and/or fatigue, sleep dysfunction, and pain; have two or more neurological/cognitive manifestations and one or more symptoms from two of the categories of autonomic, neuroendocrine and immune manifestations; and adhere to item 7.</i></p>
<p>1. <i>Fatigue:</i> The patient must have a significant degree of new onset, unexplained, persistent, or recurrent physical and mental fatigue that substantially reduces activity level.</p>
<p>2. <i>Post-Exertional Malaise and/or Fatigue:</i> There is an inappropriate loss of physical and mental stamina, rapid muscular and cognitive fatigability, post exertional malaise and/or fatigue and/or pain and a tendency for other associated symptoms within the patient's cluster of symptoms to worsen. There is a pathologically slow recovery period—usually 24 hours or longer.</p>
<p>3. <i>Sleep Dysfunction:</i>* There is unrefreshed sleep or sleep quantity or rhythm disturbances such as reversed or chaotic diurnal sleep rhythms.</p>
<p>4. <i>Pain:</i>* There is a significant degree of myalgia. Pain can be experienced in the muscles and/or joints, and is often widespread and migratory in nature. Often there are significant <i>headaches</i> of new type, pattern or severity.</p>
<p>5. <i>Neurological/Cognitive Manifestations:</i> <u>Two or more</u> of the following difficulties should be present: confusion, impairment of concentration and short-term memory consolidation, disorientation, difficulty with information processing, categorizing and word retrieval, and perceptual and sensory disturbances—e.g., spatial instability and disorientation and inability to focus vision. Ataxia, muscle weakness and fasciculations are common. There may be overload<sup>1</sup> phenomena: cognitive, sensory—e.g., photophobia and hypersensitivity to noise—and/or emotional overload, which may lead to “crash”<sup>2</sup> periods and/or anxiety.</p>

<p>6. At Least <u>One</u> Symptom from <u>Two</u> of the Following Categories:</p> <ul style="list-style-type: none"> <li>a. <i>Autonomic Manifestations</i>: orthostatic intolerance—neurally mediated hypotension (NMH), postural orthostatic tachycardia syndrome (POTS), delayed postural hypotension; light-headedness; extreme pallor; nausea and irritable bowel syndrome; urinary frequency and bladder dysfunction; palpitations with or without cardiac arrhythmias; exertional dyspnea.</li> <li>b. <i>Neuroendocrine Manifestations</i>: loss of thermostatic stability—subnormal body temperature and marked diurnal fluctuation, sweating episodes, recurrent feelings of feverishness and cold extremities; intolerance of extremes of heat and cold; marked weight change—<i>anorexia</i> or abnormal appetite; loss of adaptability and worsening of symptoms with stress.</li> <li>c. <i>Immune Manifestations</i>: tender lymph nodes, recurrent sore throat, recurrent flu-like symptoms, general malaise, new sensitivities to food, medications and/or chemicals.</li> </ul>
<p>7. The illness persists for at least six months. It usually has a distinct onset, ** although it may be gradual. Preliminary diagnosis may be possible earlier. Three months is appropriate for children.</p>
<p><i>To be included, the symptoms must have begun or have been significantly altered after the onset of this illness. It is unlikely that a patient will suffer from all symptoms in criteria 5 and 6. The disturbances tend to form symptom clusters that may fluctuate and change over time. Children often have numerous prominent symptoms but their order of severity tends to vary from day to day. *There is a small number of patients who have no pain or sleep dysfunction, but no other diagnosis fits except ME/CFS. A diagnosis of ME/CFS can be entertained when this group has an infectious illness type onset. **Some patients have been unhealthy for other reasons prior to the onset of ME/CFS and lack detectable triggers at onset and/or have more gradual or insidious onset.</i></p>
<p><i>Exclusions</i>: Exclude active disease processes that explain most of the major symptoms of fatigue, sleep disturbance, pain, and cognitive dysfunction. It is essential to exclude certain diseases, which would be tragic to miss: Addison's disease, Cushing's Syndrome, hypothyroidism, hyperthyroidism, iron deficiency, other treatable forms of anemia, iron overload syndrome, diabetes mellitus, and cancer. It is also essential to exclude treatable sleep disorders such as upper airway resistance syndrome and obstructive or central sleep apnea; rheumatological disorders such as rheumatoid arthritis, lupus, polymyositis</p>



and polymyalgia rheumatica; immune disorders such as AIDS; neurological disorders such as multiple sclerosis (MS), Parkinsonism, myasthenia gravis and B12 deficiency; infectious diseases such as tuberculosis, chronic hepatitis, Lyme disease, etc.; primary psychiatric disorders and substance abuse. *Exclusion of other diagnoses, which cannot be reasonably excluded by the patient's history and physical examination, is achieved by laboratory testing and imaging. If a potentially confounding medical condition is under control, then the diagnosis of ME/CFS can be entertained if patients meet the criteria otherwise.*

*Co-Morbid Entities:* Fibromyalgia Syndrome (FMS), Myofascial Pain Syndrome (MPS), Temporomandibular Joint Syndrome (TMJ), Irritable Bowel Syndrome (IBS), Interstitial Cystitis, Irritable Bladder Syndrome, Raynaud's Phenomenon, Prolapsed Mitral Valve, Depression, Migraine, Allergies, Multiple Chemical Sensitivities (MCS), Hashimoto's thyroiditis, Sicca Syndrome, etc. *Such co-morbid entities may occur in the setting of ME/CFS. Others such as IBS may precede the development of ME/CFS by many years, but then become associated with it. The same holds true for migraines and depression. Their association is thus looser than between the symptoms within the syndrome. ME/CFS and FMS often closely connect and should be considered to be "overlap syndromes."*

*Idiopathic Chronic Fatigue:* If the patient has unexplained prolonged fatigue (6 months or more) but has insufficient symptoms to meet the criteria for ME/CFS, it should be classified as idiopathic chronic fatigue.

### ***General Considerations in Applying the Clinical Case Definition to the Individual Patient***

1. *Assess Patient's Total Illness:* The diagnosis of ME/CFS is not arrived at by simply fitting a patient to a template but rather by observing and obtaining a complete description of their symptoms and interactions, as well as the total illness burden of the patient.
2. *Variability and Coherence of Symptoms:* Patients are expected to exhibit symptoms from within the symptom group as indicated, however a given patient will suffer from a cluster of symptoms often unique to him/her. The widely distributed symptoms are connected as a coherent entity through the temporal and causal relationships revealed in the history. If this coherence of symptoms is absent, the diagnosis is in doubt.

3. *Severity of Symptoms:* A symptom has significant severity if it substantially impacts (approximately a 50% reduction) on the patient's life experience and activities. In assessing severity and impact, compare the patient's activity level to their *premorbid activity level*. Establishing the severity score of symptoms is important in the diagnostic procedure (46,45), and should be repeated periodically. A chart for severity of symptoms and symptom hierarchy can be found in Appendix 3. While this numerical scale has been developed as a tool to assist the clinician and position the patient within the overall spectrum of ME/CFS severity, the severity and impact of symptoms should be confirmed by direct clinical dialogue between physician and patient over time.
4. *Symptom Severity Hierarchy:* Periodic ranking of symptom severity should be part of the ongoing evaluation of the clinical course. (Appendix 3) This hierarchy of symptom severity will vary from patient to patient and for an individual patient over time. Thus, although fatigue and post-exertional malaise are universal symptoms of ME/CFS, they may not be the most severe symptoms in the individual case, where headaches, neurocognitive difficulties, pain and sleep disturbances can dominate, at least temporarily. Establishing symptom severity and hierarchy helps orient the treatment program.
5. *Separate Secondary Symptoms and Aggravators:* It is important to try to separate the primary features of the syndrome from those that are secondary to having a poorly understood chronic illness in our society such as secondary stress, anxiety and depression and inactivity. It is also important to consider symptom interaction and dynamics, and distinguish the effects of aggravators and triggers.

## 3.0 The Science – Symptoms and Potential Causes

The Group heard a great deal of scientific evidence at our hearings and we also received a lot of evidence via submissions. We have included a selection here. Much of it in itself is not fully conclusive but it opens avenues for further research. The origins and causes of the whole CFS/ME problem will only be found through further scientific research.

**The Group calls for a further Inquiry into the Scientific Evidence for CFS/ME by the appropriately qualified professionals.** This Inquiry should be commissioned by government undertaken by an independent panel of scientific and medical experts, including virologists, immunologists, biochemists etc who can objectively assess the relevance and importance of the international scientific data.

### 3.1 The Oral Hearings

The Group was witness to oral presentations from the following specialists:

- Prof Trudie Chalder
- Dr Anthony Cleare
- Dr Jonathan Kerr
- Dr Vance Spence
- Professor Peter White
- Prof Malcolm Hooper
- Prof Anthony J Pinching

Full details of their presentations are available on the Groups website ([www.erythos.com/gibsonenquiry](http://www.erythos.com/gibsonenquiry)). Some presentations related to treatment rather than symptoms and causes so please see the treatments section for any person's work that is missing.

The overwhelming message from all of our speakers was that more money was needed to develop knowledge in this contentious area. There are innumerable potential causes and unusual symptoms found in CFS/ME patients, but in the UK at least, sufficient research has not been done to verify any one cause. The Group feels the necessary research must be funded immediately. Prof Peter White told us 'ring fence some money and the scientists will follow'. Below we will summarise the areas these presentations identified for further research.

#### **Genetic Research (Dr Jonathan Kerr)**

Dr Jonathan Kerr presented to the Group his genetic studies on CFS/ME. It is clear he is making significant advances in his work. Dr Kerr's results suggest that patients with CFS/ME have reproducible alterations in gene regulation. He is also carrying out further research into immunity. However much more research needs doing before there are concrete results.

#### **Cortisol/Endocrine (Dr Anthony Cleare)**

Dr Cleare presented research into the neurobiology of CFS/ME and presented his findings relating to the hormone cortisol. Cortisol levels were low in the brains of up to 50% of the ME sufferers in his studies. Although this was found only in

patients in the late stages. Hydrocortisone (cortisol replacement) supplements reduced fatigue in 28% of patients. Dr Cleare has also found that serotonin or 5HT can be overactive in the brain of ME/CFS patients. It is difficult to determine whether biological changes such as this are potential causes of CFS/ME or the result of the illness itself. This is because the long-term physical immobility that is a symptom of CFS/ME will inevitably have an effect on the body.

### **Dr Vance Spence**

Dr Spence presented on a number of biomedical areas that had shown a need for further investigation. These included blood flow to the brain, orthostatic intolerance and oxidation.

### **Prof Malcolm Hooper**

The Groups found that Dr Malcolm Hooper is an extremely important figure in the ME community in the UK. Dr Hooper is a strong advocate of the organic basis of CFS/ME. The Group found Dr Hooper's paper from 2001 "What is ME? What is CFS?" and his "Engaging with ME" DVD to be a helpful analysis of the field of CFS/ME which concurred with many of the personal documents we received from patients. Prof Hooper's paper "Myalgic Encephalomyelitis (ME): a review with emphasis on key findings in biomedical research" was published this year by the British Medical Journal .<sup>13</sup>

## **3.2 Other Evidence We Received**

### **Prof Simon Wessely**

Professor Wessely is considered by many to be the leading expert on treating CFS/ME and the CFS/ME treatment centres set up by the NHS have been to his model. Many patient groups oppose these treatments because, although they are founded on the positive results of controlled clinical trials, they are psychologically based. There is great dispute over the findings and beliefs of Professor Simon Wessely. Many patient groups believe Wessely and his colleagues are responsible for maintaining the perception that ME is a psychosocial illness. Wessely gave up the research side of his work possibly due to extreme harassment he received from a very small fringe section of the ME community.

There is conflicting evidence available regarding Wessely's true opinions. The Group invited Wessely to speak at an Oral Hearing, however he declined the offer and sent his colleagues Dr Trudie Chandler and Dr Anthony Cleare. The Group were disappointed not to have the opportunity to discuss this important issue with such a key figure. Wessely did not submit a written piece to the Inquiry, however in a letter to the Inquiry he did set out his belief that CFS/ME has a biological element which needs further research and investigation.

---

<sup>13</sup> Myalgic Encephalomyelitis (ME): a review with emphasis on key findings in biomedical research  
Malcolm Hooper *J. Clin. Pathol.* published online 25 Aug 2006; doi:10.1136/jcp.2006.042408;  
<http://jcp.bmjournals.com/cgi/content/abstract/jcp.2006.042408v1>

### Cardiology (Papers and Dr Paul Cheney)

Numerous studies have suggested that cardiac abnormalities occur in CFS/ME patients<sup>14</sup>. For example one American study found that “Our results indicate that the abnormal T-wave normal stress oscillations are a characteristic of CFS” “Moreover, the absence of these T-wave abnormalities is an excellent method (sensitivity, 0.96) to exclude the CFS in a patient with chronic fatigue of unknown cause.”<sup>15</sup> However, these results as in all results in all CFS/ME trials are based on extremely limited patient samples. In a lecture last month a Dr Paul Cheney delivered findings that 80% of his CFS/ME patients have diastolic cardiomyopathy, this work has yet to be published.

### Brain Activity/Scans (Dr Byron Hyde/Dr Paul Cheney)

Dr Cheney found as long ago as 1993 that of 12000 cases, 80% had abnormal Single photon emission computed tomography (SPECT) scans i.e. 3D images of the brain. 95% have abnormal cognitive evoked brain maps in readings from an Electroencephalograph (EEG), a recording of electric signals from the brain. These observations await confirmation.

We also received a submission from Dr Byron Hyde, also Canadian and editor of “The Clinical and Scientific Basis of Myalgic Encephalomyelitis Chronic Fatigue Syndrome”<sup>16</sup>. This is essentially an encyclopedia of CFS/ME and provided a vast array of biomedical evidence. Dr Hyde has researched a series of tests which have found irregular brain activity in 80% of ME patients. These tests include, Magnetic Resonance Imaging (MRI) scans of the brain, Positron emission tomography (PET) which is a three dimensional image or map of functional processes in the body, and SPECT. Again others have yet to confirm or refute these observations.

### Viral Effects (Dr John Richardson)

This was the second textbook the Group found to be of great use when assessing whether ME had a biomedical pathology. The book concentrates on Viral CFS/ME and examines the various effects. The NICE draft guideline makes little reference to the possibility of viral investigation in ME patients.

**The Group recommends, firstly, that these studies and others like them must be examined by an independent scientific advisory committee such as the one proposed above. Secondly, many of the studies we received were conducted on a very limited scale and their findings need to be confirmed or refuted by large-scale investigation. Until this happens, the field will remain confused.**

---

<sup>14</sup> Peckerman A, LaManca JJ, Dahl KA, Chemitiganti R, Qureishi B, Natelson BH. "Abnormal impedance cardiography predicts symptom severity in chronic fatigue syndrome." *Am J Med Sci*. 2003 Aug;326(2):55-60.

<sup>15</sup> A. Martin Lerner, James Goldstein, Chung-ho Chang, Marcus Zervos, James T. Fitzgerald, Howard J. Dworkin, Claudine Lawrie-Hoppen, Steven M. Korotkin, Marc Brodsky, and William O'Neill, "cardiac involvement in patients with chronic fatigue syndrome as documented with holter and biopsy data in birmingham, michigan, 1991-1993" *Inf Dis in Clin Pract*, 1997; 6:327-333.

<sup>16</sup> Hyde BM, Goldstein JA, Levine P, eds. *The Clinical and Scientific Basis of Myalgic Encephalomyelitis / Chronic Fatigue Syndrome*. 750 pp. Nightingale Research Foundation, 1992.

### 3.3 Potential Causes of CFS/ME

Fatigue is very common. So are aches and pains in joints and muscles, headaches, lack of concentration and stomach and bowel disturbances. They are particularly common following infectious illnesses such as flu or glandular fever but it is only when these symptoms are particularly severe or prolonged that patients, relatives and medical attendants begin to suspect that there may be something more going on and a diagnosis of CFS/ME is entertained.

This association with infections has prompted a search for infective agents and there is now reasonably convincing evidence that some infections do precipitate the illness. A variety of candidates are likely including infectious mononucleosis, influenza viruses and adeno-viruses. Tests may indicate that patients have had one or other of these infections in the past but are not necessarily infected at the time they develop their symptoms.

Why do some patients go on to get CFS/ME and others recover fully after these infections? It may be that just as these infections in their acute phases affect patients in different ways, with different degrees of severity, dependent on such known factors as dose of infection, virulence of the strain or individual susceptibility so similar factors may determine which patients get severe CFS/ME and others recover fully. Research has focussed on each of these possibilities but a search for continuing active infections has been uniformly negative even though tests of past infections remain positive as they do in those who recover fully.

Attention therefore has turned to factors which might determine individual's susceptibility. Abnormalities have been detected in the immune system in CFS/ME patients but these are not necessarily specific and it is as yet unclear whether they are the result of the illness or contributing to its cause. Changes in MRI scans of the brain and in the endocrine system are also reported but again their specificity for CFS/ME is unproven and whether they result from the illness or are involved in its cause requires much further work. Inflammatory changes in the spinal cord found in a small number of post mortem specimens also points to the need for more research. Unfortunately none of these changes have yet been proven to be specific for the disease since similar findings are detected in other conditions and it is not yet possible to determine whether these changes are the result of the disorder or are its cause. Some genetic tests now suggest the possibility of a genetic predisposition to the illness. This could be a fruitful area for future research although the simple finding of a genetic predisposition does not necessarily mean we will be nearer to finding a cure. **Future research therefore needs to focus on efforts to categorise the illness or illnesses and on possible infective or other precipitating causes and into the factors contributing to a person's predisposition to the disease.**

#### 3.3.1 Lyme Borreliosis

A lot has been made of the link between CFS/ME and Lyme's disease or Lyme Borreliosis. The group heard from many patients who were convinced they had it, some who had tested positive and found treatments and others who thought Lyme Borreliosis had not link to CFS/ME. Following discussions with the Health Protection Agency the Group concluded that Lyme Borreliosis is a potentially serious illness and was concerned to discover that is in on the increase in the UK.

However, while those with Lyme Borreliosis exhibit many similar symptoms to CFS/ME the Group believes they are two separate afflictions.

### **3.3.2 Viruses**

The Epstein Barr virus was thought to be principally responsible for CFS/ME for some time, the more recent virus to enter the debate is the Coxsackie. This is because they have an immunosuppressive effect which potentially causes the symptoms of CFS/ME. Viruses are areas which need further research. It is clear that fatigue is a much recorded post-viral symptom. However, there is not enough research evidence to determine whether post-viral CFS/ME is a separate illness from CFS/ME.

### **3.3.3 Organophosphates**

There are indications that some people, particularly children, who have a diagnosis of CFS/ME were exposed to organophosphate (OP) pesticides before they became ill. OP's are known to affect, in particular, the peripheral and autonomic nervous systems, and may also affect other functions, though there is as yet insufficient scientific evidence to show which.

For many years young children have been exposed to OP's through head louse shampoos and from close contact with pets wearing OP impregnated collars or with furnishings and carpets sprayed with OP's to treat flea infestations. Adults have been exposed occupationally as well as from the use of OP products in their homes and gardens.

The symptoms associated with the chronic effects of exposure to OP's are very similar to those for CFS/ME. It is essential that a comprehensive history of possible occupational and recreational exposures to these toxic chemicals is taken in order to exclude OP poisoning as a diagnosis. Again research should be designed to test any hypothesis.

### **3.3.4 Vaccination**

Vaccination is often blamed for unexplained outbreaks of illness and regularly appears in the media being accused of such. The Group found that there is no strong evidence to link CFS/ME to vaccination and it is unlikely to be a cause. However this is a possible area for further investigation.

## **4.0 Treatment**

### **4.1 Treating the Unknown**

At least as important as research into causes is that into potential new therapies. A wide variety of therapies have been tried but a consistent pattern of what is effective in most patients has not emerged. Vitamin supplements are commonly tried usually without reproducible effects. Massage and physiotherapy may provide some relief but do not affect the underlying and persisting problem. Antidepressants are often prescribed but only benefit those who are also depressed or anxious. In common with many other diseases of unknown cause a variety of unorthodox therapies have been tried without consistent effect.

### **4.2 Existing Treatments**

There are 3 psychosocial therapies commonly used to treat CFS/ME in the UK. Psychosocial methods of treatment do have a role to play as the relation between mind and body in disease is complex. Patients selected for trials of these treatments are likely to have been selected using the Oxford Criteria.

### **4.3 Cognitive Behavioural Therapy**

The most effective psychological therapy, which has been shown as such in controlled clinical trials, is Cognitive Behaviour Therapy (CBT). This treatment has shown to be effective in patients with many long term illnesses for example cancer. Prof Trudie Chalder presented to the group on this treatment. Prof Chandler's results were impressive. This treatment certainly has a role to play in treating CFS/ME. Although in other illnesses this treatment is provided as an adjunct to treatment for the organic disease, in CFS/ME this, and GET (see below), are the only available treatments which have been shown to be effective in several controlled trials. It is unfortunately the case that no other treatments have yet emerged, again emphasising the need for more research.

CBT is most effective in those with less severe forms of CFS/ME and appears to be much less effective in those with severe disease. As mentioned earlier this has led to some patient groups, speaking for those with severe disease, to deny that those with the less severe CFS/ME symptoms are true CFS/ME sufferers. It is clear however that no matter how successful or unsuccessful CBT may be it is at best only a partial answer. Prof Chalder suggested that CBT has a biological effect on the body. The Group would like to see further research into what this effect is as it may open avenues of investigation into biomedical causes.

### **4.4 Graded Exercise Therapy**

GET is one of the most common treatments for CFS/ME. It is recommended in the NICE Draft guidelines. The psychosocial treatments above are useful for many illnesses and situations and have not been found to be harmful to patients with CFS/ME. However GET is an area for particular concern. The evidence given to the Group by Dr Peter White found that in four studies 50-70% of patients improved



with GET<sup>17</sup>. However, Dr White also states that “GET (and CBT) have been shown to be efficacious only in small trials. They have never been compared to specialist medical care or pacing. We do not know the best treatment; for whom; nor how they work”<sup>18</sup> In separate oral evidence, Dr Vance Spence directed us towards the 25% ME Group findings that only 5% of their members found GET helpful and 95% found it unhelpful<sup>19</sup>. Many patients who submitted personal evidence to the inquiry had similarly negative experiences of GET.

Given the evidence from patients and Dr White the Group is concerned that the NICE guidelines are recommending these treatments without caveats.

We heard suggestions that there is a risk of heart trouble in patients with CFS/ME. This has serious implications for GET. As such the group would recommend that the heart function is examined, especially in the severely affected, before GET is recommended.

## 4.5 Pacing

Pacing is a method of managing energy. As the name suggests the patients pace themselves. They only move around or undertake activities to the extent that they are comfortable, the idea being that they will not fully exert themselves if they do this. Pacing is a useful tool for managing fatigue and patients with other illnesses such as Parkinson’s and MS also find it to be effective.

## 4.6 A Holistic Approach

Patients with milder forms of CFS/ME are usually easier to treat and more often relieved of their symptoms than those with severe disease. Treatments which have been claimed to help such patients include Cognitive Behaviour Therapy and pacing but on the whole these are not successful in the severe forms of the disease. This has led those with the severe form to believe that these types of therapy are of no value or even harmful. A number of issues emerge from this background.

If the above treatments are prescribed, they should be regarded as symptomatic treatments, not as cures. In the absence of any alternative or better treatments and of a better understanding of what causes the disease these methods simply help patients deal better with their symptoms, albeit hastening the recovery in at least some patients. It also has to be accepted that in patients with severe CFS/ME these treatments may be may be ineffective. Their observation that GET may make severe sufferers feel worse has lent fuel to their often serious antipathy to the doctors offering it. Some of our evidence suggests that GET carries some risk and patients should be advised of this.

---

<sup>17</sup> <http://www.erythos.com/gibsonenquiry/Docs/White.ppt#346,12,Percentage improved with GET>

<http://www.erythos.com/gibsonenquiry/Docs/White.ppt#351,13,Percentage improved with GET>

<sup>18</sup> <http://www.erythos.com/gibsonenquiry/Docs/White.ppt#273,14,Controversies in treatment>

<sup>19</sup> <http://www.25megroup.org/Group%20Leaflets/Group%20reports/March%202004%20Severe%20ME%20Analysis%20Report.doc>

It seems probable that, as with most other diseases, there is likely to be a physical element and a psychological element to the illness. Therefore successful treatment pays attention “holistically” to the whole person, caring for the mind and body. For some doctors to deny the existence of a physical part of the illness is as equally unhelpful as the claim by some patient groups that there is no psychological element to the disease.

The close link with depression in many ME cases may be explained by the nature of the illness. It is likely the inactivity and lethargy caused by the ME combined with psychological aspects such as the sense that professionals do not believe them, social stigma, lack of classification or possibility of a cure, leave the ME sufferer more disillusioned than those with other chronically disabling diseases and thus more prone to depression. **However, all diseases have an admixture of the two and teasing out the contribution each makes in an individual patient is clearly an important matter for further research.**

## **4.7 Other Treatments**

Other treatments tried include antibiotics, antivirals and anti-inflammatory agents but none have been shown to be effective. Carefully conducted, controlled trials of these and other unorthodox therapies will be necessary if they are to become acceptable.

### **4.7.1 Pharmacological**

Drug therapies are uniformly disappointing in the treatment of severe CFS/ME. Palliation may be helpful and should be attempted. Analgesics and anti-inflammatory agents may provide some pain relief as they can act on the myalgia. Opiates must be used as a last resort because of the probability of addiction and then only after full advice and appropriate treatment from a specialist pain clinic. Symptoms of Irritable Bowel Syndrome should be treated specifically. If depression is felt to be a significant result from the illness and contributing to its overall effects then anti-depressants may help if prescribed with full explanation by the doctor. Other symptoms should be treated only when the doctor has absolutely excluded any other underlying organic illness that could be the cause.

### **4.7.2 Diet and Supplementary**

There is no scientific proof of benefit from the use of vitamin or other dietary supplements. However if any of these have been found symptomatically helpful by individual patients the effect should be welcomed but a search through the shelves of the health food shops should not be encouraged with any optimism

### **4.7.3 Complementary and Alternative Therapies**

Acupuncture, reflexology and aromatherapy for example are being used with success as complementary therapies in palliative care for malignant diseases and may be helpful in relieving symptoms in some patients with CFS/ ME. It is unlikely these therapies will be available under the NHS. Wider availability of these therapies under the NHS would be another advantage of the recognition of CFS/ ME

### **4.7.4 Unorthodox Therapies**

The group was intrigued but sceptical about the claims of therapeutic success for

unorthodox methods of treatment and the description of not generally recognised physical signs said to be diagnostic of authentic ME. However unlikely such claims may appear it is important that they are not discarded as unworthy of scientific study. Until we have more knowledge about the cause of CFS/ ME any suggestion of helpful, empirical treatments such as the Perrin technique, aimed at increasing lymphatic drainage in the chest and neck, require independent assessment in a controlled environment.

## 5.0 Government Provision: Service Structure & Research

### 5.1 Treatment Centres

The £8.5 million ring fenced by the DOH was used in part to set up 13 new CFS/ME treatment centres nationwide. We were informed of new services (at the treatment centres) in England and the problems of delivery which were being addressed in the centres. The Group is extremely pleased with the advent of these centres and we hope they will be maintained and indeed rolled out. However, there is clearly a need for research into causation, the spectrum of the illness over time, therapeutic interventions and models of care. It is indeed surprising that, given the talent and interest that there is, huge frustration remains in providing funding for research and the different approaches to research. The NICE guidelines must surely recognise the inadequacy of our knowledge in all these areas and indeed we may inhibit discovery and make profound mistakes in the absence of a national, all round research policy. Professor Malcolm Hooper has been a major advocate of the progressive nature of the illness with attendant neurological efforts. He clearly thinks there is room for a more wide ranging approach involving physical explanations. Others confirmed this approach was also necessary in children ages 9-16. It would be tragic if the NICE guidelines fail to accept that, as the causes and pathogenesis of ME/CFS remain poorly researched and therefore treatments are multifarious, empirical and only of marginal symptomatic help in some cases. Our international witnesses illustrated graphically and vividly the confusions in their field of research and NICE will certainly benefit from listening to international experts. **The existing treatment centres would be ideal places to undertake or initiate large-scale epidemiological research studies of the type the Group feel are vital in this field. Providing they were conducted according to an acceptable criteria.**

### 5.2 Research Issues

The underlying theme in all or our hearings was the paucity of research into causes. The committee welcomes the recognition of the need to sustain treatment centres. However exactly which treatments should be used on which patients remains disputed. Treatment may change after more research. Provision of resources for biomedical research is urgently needed. The committee would like to see a similar arrangement to the AIDS programme funded previously by the MRC.

The Minister indicated to the inquiry that few good biomedical research proposals had been submitted to the MRC in contrast to those for psychosocial research. We have however been told of proposals that have been rejected, with claims of bias against support for this type of research. The MRC should do more to encourage applications for funding into biomedical models of CFS/ME.

The CMO's Working Group report came out in January 2002. Despite paying lip service to the need to advance the understanding of CFS/ME, the MRC itself has confirmed that from April 2003 to date, it has turned down 10 biomedical

applications relating to CFS/ME because they considered they were not of high enough scientific standards to compete against the many calls on its funds. These included applications under the headings of pathophysiology, genetics, biomarkers, immunology and neuroimaging.

By contrast, since April 2003 the MRC has funded five applications relating to CFS/ME, mostly in the psychiatric/psychosocial domain (Professor Francis Creed, Professor K Bhui, Professor Peter White's PACE trial, Alison Wearden's FINE trial and Richard Morriss' study of "medically unexplained symptoms"). These are to be welcomed of course since they are largely concerned with efforts to confirm or refute the nature of different forms of therapy in carefully controlled trials. However it is important for the MRC to be seen to be balancing this with support for more high quality basic research into potential causes.

Biomedical applications in respect of CFS/ME known to have been rejected include those by Professor Jill Belch (herself a Principal Fellow of the MRC) and Dr Vance Spence of Dundee, as well as Dr Jonathan Kerr of St Georges, London.

It is clear that internationally there have been a number of studies, which have identified clear areas for further research. The MRC should commissions British versions of this research in order to advance possible treatments.

The group were concerned by the MRC CFS/ME Research Advisory Group paper. The Research Advisory Group advocates concentrating research effort on case management and "potential interventions" rather than cause, pathogenesis or means of confirming the diagnosis saying this approach is as appropriate for CFS/ME "as it is in other illnesses" of unknown cause. The Group is concerned that this diverted attention away from the need for more research into causation and diagnosis. The Group feels that CFS/ME cannot be viewed in the same light as other illnesses of unknown cause such as the malignant diseases which can be diagnosed with appropriate existing investigations. The crucial issue with CFS/ME is to identify diagnostic tests for it even before its cause is clarified. Of course you can research the effects of treatment of a proven specific cancer without knowing its cause. The same does not apply to an illness where the diagnosis has not been positively confirmed.

## 6.0 Benefit entitlement

### 6.1 Patient Experiences

People with CFS/ME, like others, often experience great difficulty in obtaining state sickness and disability benefits and this is reflected in the very high proportion who only succeed by going through the stressful and bureaucratic appeals procedures.

At present CFS/ME is defined as a psychosocial illness by the Department for Work and Pensions (DWP) and medical insurance companies. Therefore claimants are not entitled to the higher level of benefit payments. We recognise that if CFS/ME remains as one illness and/or both remain defined as psychosocial then it would be in the financial interest of both the DWP and the medical insurance companies.

The Groups feels that patients with CFS/ ME, which is often an extremely long term condition, should be entitled to the higher rate DLA. The sooner there is a biomedical model of assessment for this illness the better. If a virus causes the CFS/ME then the patients should be entitled to the higher rate DLA.

### 6.2 What The Government Says

Below is an excerpt from Hansard;

*“18 Dec 2002 : Column 853W*

#### **Disability Living Allowance**

**Mr. Peter Duncan:** To ask the Secretary of State for Work and Pensions whether a claim for Disability Living Allowance in respect of ME may be classified as relating to mental illness. [87128]

**Maria Eagle:** Entitlement to Disability Living Allowance depends on the effects that severe physical or mental disability has on a person's need for personal care and/or their ability to walk, and not on particular disabilities or diagnoses. The benefit is available to people with myalgic encephalomyelitis (which can have a physical basis or a psychological basis, or can be due to a combination of factors) on exactly the same terms as other severely disabled people, and they can qualify for it provided that they meet the usual entitlement conditions.”<sup>20</sup>

It is clear that, until a biomedical cause is researched and identified, CFS/ME patients will continue to find it difficult to receive higher rate DLA. CFS/ME patients do qualify on the same basis as other disabled people, but they are at a massive disadvantage because of the controversy surrounding the cause of their illness and suggestion that it may be psychosomatic.

Evidence suggests that benefits agency staff often err on the side of caution. A survey conducted by the 25% ME Group in March 2004 found evidence that 59%

---

<sup>20</sup> Hansard *18 Dec 2002 : Column 853W*

of CFS/ME patients who applied for DLA were unsuccessful on their first attempt. Of those 86% appealed and of those 85% were successful in their appeal.

The Group heard a number of extremely disturbing testimonials from patients. These included patients whom had been dismissed by their GPs as 'attention seeking' or indeed malicious in intent. The DWP is reliant on medical opinion when determining benefit entitlement for DLA. Until medical opinion is better informed as to the nature of this illness CFS/ME sufferers will have to live with the double burden of fighting for their health and their benefits.

### **6.3 How the Department for Work and Pensions Formulates CFS/ME Policy**

There are genuine problems in the benefit assessment procedures for CFS/ME and as yet there is no agreement on new written guidance to replace that which is currently in use. This consultation process, involving meetings and redrafting, has been going on for over a year, but government looks like adopting a new benefits policy which may still leave it discriminating against claimants with CFS/ME.

There have been numerous cases where advisors to the DWP have also had consultancy roles in medical insurance companies. Particularly the Company UNUMProvident. Given the vested interest private medical insurance companies have in ensuring CFS/ME remain classified as a psychosocial illness there is blatant conflict of interest here. The Group find this to be an area for serious concern and recommends a full investigation of this possibility by the appropriate standards body. It may even be that assessment by a medical 'expert' in a field of high controversy requires a different methodology of benefit assessment.

## 7.0 Conclusions

### **7.1 The Group's Response**

The Canadian Criteria are a useful contribution to the attempt to define the clinical condition of CFS/ME

There are arguments relating to whether ME and CFS are separate illnesses. Opinion on this matter is split, both within the Group and in wider society. The only way to resolve this dispute is through a massive further research programme involving large patient groups.

The Group was very interested in the international evidence submitted and concerned as to why this evidence has not been seriously examined in the UK. **The Group calls for a further Inquiry into the Scientific Evidence for CFS/ME by the appropriately qualified professionals.** This Inquiry should be commissioned by government undertaken by an independent panel of scientific and medical experts, including virologists, immunologists, biochemists etc who can objectively assess the relevance and importance of the international scientific data. There is a perception that much of the international research is not peer reviewed. The Group has found this to not always be the case and has received research published in UK and international journals.

The opposing opinions about the nature of the disease are very problematic. On the one hand, it is thought of as a physical, multi-system disease with, in some cases, inevitable reactive depression. On the other, most distressingly for patients, it is thought of as a psychoneurotic illness with secondary physical features. The lack of easy confirmation of the organic nature of the illness by a readily available investigation lends itself to occasional invasion by those who are not genuine sufferers. The existence of such patients and the inability of some in the medical profession to separate them from genuine patients with CFS/ME enhances the view that all patients with CFS/ME are neurotic and/or not genuinely ill.

We think that CFS/ME is likely to be similar to every other disease in having a spectrum of severity between those with severe and mild forms of the disease and in their responsiveness to treatment. This is true of such widely different diseases as cancer, TB, arthritis and dementia.

Forms of therapy, which have been shown in controlled trials to be of clear value to some patients, should not be denied to patients even though it does not help others with more severe disease. Each patient should be informed about his or her options and the possible consequences of treatment and then be allowed to make up their own mind. We agree with the NICE guideline that refusal of treatment by patients should not affect patient doctor relationships. Neither must requests for treatment.

As in most diseases it is almost always helpful to treat diagnosed patients as early as possible; it is likely that this will be true of CFS/ME too. Unfortunately, with



some patients, the onset of severe symptoms is acute and it may not be possible to catch it early on. In others, however, it seems entirely reasonable to make every effort to offer relevant treatments when symptoms first begin and when they may be relatively milder. If patients are prevented from developing more severe disease then that must be worthwhile even though it may not be possible to prove that they have “true” CFS/ME retrospectively.

The Group recognises that fatigue may have many causes, indeed chronic fatigue may also be symptom of other illnesses. As such, it may react well to psychological treatments. However, severe cases of CFS/ME do not respond so well to psychological treatment and this must be investigated further.

ME and CFS have been defined as neurological illnesses by the World Health Organisation. Various clinical and epidemiological research studies in countries around the world have suggested CFS/ME to have a biomedical cause. The UK has not been a major player in the global progress of biomedical research into CFS/ME. Although some interesting biomedical research has been done in the UK precedence has been given to psychological research and definitions. **The Group believes the UK should take this opportunity to lead the way in encouraging biomedical research into potential causes of CFS/ME.**

There is a great deal of frustration amongst the CFS/ME community that the progress made in the late 1980s and early 1990s toward regarding CFS/ME as a physical illness has been marginalised by the psychological school of thought. It is clear the CFS/ME community is extremely hostile to the psychiatrists involved.

The Group does not intend to criticise the motivations or actions of any one group, our aim is to build consensus from this point forward. Indeed the Group wishes to avoid being distracted by debates centring on semantics in this difficult and contentious field. The principle actuality remains, that there exists a serious disease, which causes much suffering for patients, which may be severe and incapacitating and which causes a multitude of symptoms. This is the baseline from which all else should follow.

## 7.2 Areas for Further Examination

1. Is this one disease or two – CFS/ME or CFS and authentic ME? Is there a clear distinction or is it a spectrum? Large-scale epidemiological studies of large populations of patients will help delineate subsets of patients.
2. Why does the DOH not keep or collect data pertaining to the number of CFS/ME sufferers in the UK? The NICE guideline says “there is a lack of epidemiological data in the UK which means that population estimates are based on extrapolations from other countries”<sup>21</sup>.
3. No representative who appeared at the Oral Hearings proposed CFS/ME was entirely psychosocial. So why has this model taken such a prominent role in the UK?

---

<sup>21</sup> NICE draft guideline Page 38

4. The Research areas defined by the CMO Report in 2002 have not been addressed. Further research is the single most important area in this field.
5. There is a need for diagnostic tests but this is likely to be dependent on a greater understanding of possible causes.
6. There is a need to undertake further research of post viral infective cause in carefully controlled studies.
7. The evidence for a toxin aetiology requires critical and controlled studies. This includes research into possible causes, like pesticides.
8. There is a great deal of anecdotal evidence of a variety of causative agents. If such causes are to be convincing the possibility of simple coincidence has to be rigorously excluded by careful research.
9. Much more study should be centred on the reasons why some individuals are susceptible to developing the illness or illnesses. These include further follow-up of immunological, endocrinological and neurological disturbances.
10. Research into further treatments is required but, in the absence of a known cause or causes which could be addressed with specific therapy, all current treatments are symptomatic and aimed at helping patients cope with their illness.
11. Although a number of controlled clinical trials were presented to us, there is a great need for large scale trials. Any new treatments will also require independent assessment in a controlled environment.
12. The MRC should call for research into this field recognising the need for a wide ranging profile of research. The committee would like to see a similar arrangement to the AIDS programme funded previously by the MRC.
13. An independent scientific committee must examine the wealth of international research data. To exclude it from the debate is a great injustice to patients.

We recommend that this condition be recognised as one which requires an approach as important as heart disease or cancer. There is no compelling evidence it is a purely psychosocial. Where the disease or diseases fit in the spectrum of psycho or biomedical disturbances in any individual requires much further research. However, this will depend on well-funded research that must be made a priority in our health research programme.

Despite the findings of the CMO's Report some three years ago. There has been no massive investment in funding of research into ME. Instead, we have seen a review of treatment by NICE based on existing evidence and existing symptomatic

techniques. We must research to find alternatives.

### **7.3 The Immediate Future**

This group believes that the MRC should be more open-minded in their evaluation of proposals for biomedical research into CFS/ME and that, in order to overcome the perception of bias in their decisions, they should assign at least an equivalent amount of funding (£11 million) to biomedical research as they have done to psychosocial research. It can no longer be left in a state of flux and these patients or potential patients should expect a resolution of the problems with only an intense research programme can help resolve. It is an illness whose time has certainly come.