

Chronic fatigue syndrome comes out of the closet

Barbara Sibbald

In brief

AN ALBERTA COURT RULING and new guidelines for physicians issued by the Quebec medical college are giving chronic fatigue syndrome a legitimacy it never before enjoyed. What will this mean for physicians?

En bref

UN JUGEMENT D'UN TRIBUNAL albertain et de nouvelles directives à l'intention des médecins publiées par le Collège des médecins du Québec donnent au syndrome de fatigue chronique une légitimité sans précédent. Quelles en seront les répercussions pour les médecins?

Chronic fatigue syndrome (CFS) is gaining unprecedented legitimacy in Canada because of a recent Alberta court ruling, new guidelines from the Quebec medical college and recent research suggesting that the syndrome may have a biological basis. There is little doubt these developments will affect physicians across Canada.

Although viewed as a modern phenomenon, CFS was first reported by Hippocrates and has been known this century under various names: myalgic encephalomyelitis, Iceland disease, Epstein-Barr virus and yuppie flu. It has been labelled as CFS since 1988, and is currently estimated to affect 20 000 to 30 000 Canadian adults. According to the Centers for Disease Control and Prevention, CFS involves chronic fatigue for at least 6 months and a minimum of 4 other symptoms (p. 519). Scientists and doctors have been debating its existence and symptoms for years, but the debate may be winding down because of an Alberta court case (p. 533).

In March an Alberta woman finally won her case against Crown Life when the court ruled that she qualified for long-term disability benefits because of CFS. The well-publicized case emphasized the difficulty physicians have in diagnosing the illness, and the Alberta College of Physicians and Surgeons hopes to respond with CFS guidelines within a year. Dr. Brian Ward, the assistant registrar in charge of standards, says the college's interest "began long before the case." He says it has received frequent complaints from patients with CFS who can't find physicians willing to treat them or follow their conditions. "They've asked us to increase the level of awareness among physicians and to provide education," says Ward.

The college will begin developing the guidelines by meeting with patients to determine what skills and knowledge physicians need to provide more consistent service. Ward says CFS involves a "fairly elaborate work up," much of which can be done by primary care physicians. "Often just a standard is needed so doctors feel comfortable," he says.

The Collège des médecins du Québec has published Canada's only CFS guidelines. Released in June, the 15-page guidelines define CFS and provide current information on its epidemiology, etiology, medical evaluation, diagnosis and treatment.



Features

Chroniques

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‡ See related articles pages 519 and 533



"The main goal of the guidelines is to help physicians help patients," says Dr. André Jacques, director of the college's practice and enhancement division. Patients were complaining to the college that GPs were unable to provide treatment and referred them to specialists. Many of the patients then had to wait months. "We think GPs can take care of CFS patients with a minimum of knowledge," says Jacques. The guidelines were 2 years in the making and included a review of scientific literature and expert input from 5 physicians, including 2 microbiologists.

Canada has been a little slow off the mark: CFS is already recognized by the World Health Organization, the US Centers for Disease Control and Prevention and, as of July, the British government.

Recent research

Despite that recognition, some physicians doubt there is a biological basis for CFS and postulate that it involves some form of depression or anxiety. However, some research points in another direction. Most of it focuses on the roles infection, the immune system and hormones may be playing (see sidebar).

Dr. Sean O'Sullivan, a general practitioner and psychotherapist from Tillsonburg, Ont., who treats patients

with CFS, holds great hope for new findings from a Philadelphia researcher. Dr. Robert Suhadolnik, a professor of biochemistry at Temple University, has found a statistically significant dysregulation in one of the antiviral pathways in CFS patients. The test is now being applied in the Netherlands and paid for by its health services. "The tide of experimental evidence is turning inexorably in favour of a biological basis [for CFS]," says O'Sullivan.

In fact, there's a movement in the US to drop "syndrome" from the name to acknowledge this biological basis.

All the new research may also affect how physicians view, and treat, CFS patients. "We won't have to wait for this generation [of doctors] to die before the disease is acknowledged," says O'Sullivan. "I've seen patients who have had their charts hurled at them by physicians."

Treatment options

The Public Health article in this issue (p. 519) provides an approach to diagnosing and managing CFS patients; *CMAJ* also asked 3 physicians how they treat the illness. O'Sullivan has seen about 500 CFS patients since 1986, while Dr. Ian Bowmer, the dean of medicine at Memorial University, has been seeing these patients since the early 1980s and now treats about 60 of them. And Dr. James

A physician's life with CFS

"Chronic fatigue syndrome made me feel like there was toxic waste in my veins," says Dr. Sean O'Sullivan. "I'd never experienced anything like it. It's not like the fatigue after a workout — you are completely exhausted. You feel you have been poisoned."

O'Sullivan, a GP from Tillsonburg, Ont., is a textbook patient for CFS. A hard-working general practitioner with a very active personal life that included white-water kayaking and martial arts, he'd heard about CFS in medical school — at the time it was called Icelandic disease — but he'd never diagnosed a case. "I'd see some and I'd do testing and would say, 'I can't find anything wrong with you, take vitamins, rest, do some exercise.'"

O'Sullivan gained personal experience with the syndrome in 1984. He says he was part of a cluster of cases. His sister-in-law, an ER nurse, and a number of her colleagues also got ill. The nurse had an eye infection that both O'Sullivan and his wife, a psychotherapist, contracted. They all wound up with CFS.

O'Sullivan lost 4 months' work in that first year. In

1985 the medical literature said it lasted 6 weeks to 18 months, so he went back to work full time: delivering babies, working nights on call and emergency, and sleeping poorly. He did it for a year, relapsed, took 4 months off, worked another year, had another relapse, and took 6 months off.

By 1988 he'd learned his lesson and went back to work slowly, gradually increasing his workload. He also started training in psychotherapy and began to see more CFS patients. "I'm much better than I was 10 years ago," says O'Sullivan, 53. "Medicine made no difference, just time." He also tried alternative therapies — evening primrose oil among others — and nothing worked.

He still doesn't talk much to his colleagues about the condition. "There's no point," he says. "They're not interested." He thinks the Quebec guidelines will help change things a little, but real change will only come with proper scientific results. "This disease," he says, "changed my life completely."



McSherry, a professor of family medicine at the University of Western Ontario who also treats a large number of CFS patients, says it is time physicians learned more about the syndrome. "This is a small group of people we haven't served well," he says.

Because neurally mediated hypotension has been associated with CFS, the 3 doctors begin treatment by determining whether this condition is present through tilt-table testing and, if necessary, treating it. They then take a 3-pronged approach by establishing proper sleeping patterns with low doses of tricyclic drugs, treating comorbid conditions and using cognitive behavioural therapy and graded exercise.

Cognitive behavioral therapy can be useful in breaking the cycle of overdoing things, says O'Sullivan, who advocates graduated exercise and work but is cautious: for the

very ill, exercise can be crippling. "Some people can't walk upstairs without resting. If they walk around the block they have to rest 2 days because of muscle pain." Doing too much too soon can cause a relapse, as O'Sullivan knows from personal experience (see sidebar).

Many employers are also inflexible. "The work environment many of these patients come from can only be described as pathological," O'Sullivan says. "Employers want them back 100% or not at all." He spends a lot of his time helping people get back to the workplace.

"They need regular, consistent exercise — a 10-minute walk even — to stave off the downward spiral to deconditioning," adds McSherry. He also advises patients to pay careful attention to their diets, to take a multivitamin and to abstain from alcohol.

O'Sullivan cautions his patients about alternative ther-

The search for a cause continues

Theories of the pathogenesis of chronic fatigue syndrome have proliferated since the 1980s. Recent research, some of which is outlined below, has focused primarily on the possible role of infectious, immunologic and hormonal factors.

CFS as sequela of infection

- Many investigators have hypothesized that CFS is a manifestation of chronic infection or is triggered by an acute infection with any or all of the following pathogens: Epstein-Barr virus, human herpes virus-6 and -7, enterovirus, coxsackievirus, parvovirus B19, Q fever, a novel retrovirus, Borna disease virus, *Bruceella*, Lyme disease, *Candida* and a newly discovered bacterium (*Mycoplasma incognitus*).
- Investigators have found no relationship between CFS and hepatitis B vaccination.
- A recent trial has suggested that an abnormality in an antiviral lymphocyte enzyme system (the 2-5A pathway) may be implicated in the pathogenesis of CFS.

CFS as a manifestation of chronic immune activation

- Some studies suggest that patients with CFS have altered immune function and aberrant production of cytokines compared with normal controls: in-

creased levels of activated CD8+ cytotoxic T cells, circulating immune complexes and immunoglobulin G, autoantibodies, TGF-beta, atypical lymphocytes and somatomedin C, and decreased function of natural killer lymphocytes. However, other studies have found no circulating pathogenic antibodies against muscle or the central nervous system, no immunoglobulin subclass deficiencies and no benefit from intravenous immunoglobulin therapy in a randomized controlled trial.

CFS as hormonal dysfunction

- A few studies suggest that some women with CFS are more likely to have excessive body hair, inappropriate breast milk production, endometriosis, uterine fibroids, ovarian cysts, irregular cycles and difficulties with conception.
- One study has investigated whether altered sensitivity to estradiol and progesterone may play a role in producing abnormal interleukin-1-beta secretion in CFS patients.
- Although some patients with CFS have been shown to have increased prolactin, decreased corticotropin and decreased cortisol levels (opposite to the profile seen in patients with depression), no benefit with cortisone replacement has been demonstrated. — *Dr. Caralee Caplan, CMAJ fellowship editor*

apies and medicines that can be extremely expensive but offer no proven benefit. If patients want to try an alternative therapy he tells them to try one thing at a time, for 6 to 12 weeks.

McSherry's says physicians have a huge role to play in advocating for patients with CFS by establishing that they are sick and helping them get benefits.

Insurance coverage

Insurance companies are understandably worried about this. Claims from what McSherry calls the 3 sleeping giants — fibromyalgia, CFS and repetitive strain injury — could be devastating, he says. Still, he's frustrated by the "song and dance" his patients get. He says insurance companies typically begin by denying the existence of CFS, and then deny that the patient has it. Then they don't want to accept what the patient's doctor says. Finally, they claim patients aren't as disabled as they say they are. Patients are then sent for a 2- or 3-hour disability assessment that McSherry says can't possibly measure their ability to perform work.

Bowmer says insurers need to take an approach with CFS patients that is different from the one taken with those who have physical disabilities. He knows of cases where patients have been videotaped hanging their washing and told they can therefore return to work. "The problem with CFS is you can do things, but you pay the price in post-exercise fatigue."

O'Sullivan says the lack of objective evidence puts insurers in an "understandable quandary" but the companies are more accountable now and the Alberta case may help to substantiate claims for long-term disability claims. O'Sullivan says he usually helps patients by giving in-

surance companies a lengthy explanation of symptoms and the degree of disability.

Dr. François Sestier, a past-president of the Canadian Life Insurance Medical Officers Association, relies on his company's protocol for determining whether someone has CFS and is eligible for long-term disability payments. He says Blue Cross depends on the CDC guidelines, a documented history of infection and diagnosis from 2 experts: a psychiatrist and an independent medical examiner, usually a microbiologist. "It's much easier now that we know how to handle it," says the Montreal cardiologist.

Sestier says he knows CFS does exist, but "90% of diagnoses put forward by physicians are not real CFS." He says physicians are misusing the term because "patients put pressure on them. Often they have a conflict at work so they hide behind the diagnosis to avoid returning to work."

Insurance scam?

Due to the lack of diagnostic tools, CFS could be construed as the ideal insurance claim for scam artists. However, the 3 doctors consulted by *CMAJ* patients say there's no benefit to faking this illness because its real victims stand to lose their jobs, friends and standing in the community. Certainly their quality of life deteriorates. American researchers have found that even though a large number of patients seek primary medical care for CFS, only 2% to 5% meet the criteria. "Why would people willingly put themselves through such an ordeal?" McSherry asks.

"You can hardly say a professor or successful businessman now living on a small pension has made a lot of gains," adds Bowmer. "The vast majority of patients are legitimate." ?