



**Myalgic Encephalomyelitis/  
Chronic Fatigue Syndrome:**

**A Clinical Case Definition  
and Guidelines for  
Medical Practitioners**

**An Overview of the Canadian  
Consensus Document**

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## The Canadian Consensus Document on ME/CFS

Our comparison study examined differences between patients meeting the Canadian clinical and the Fukuda et al. criteria for ME/CFS, with people who had chronically fatiguing illness explained by a psychiatric condition. The Canadian Clinical Criteria selected patients with more physical functional impairment, more fatigue/weakness, neurocognitive and neurological symptoms and had more variables that significantly differentiated them from the psychiatric comparison group than did the Fukuda et al. criteria. The findings do suggest that the Canadian criteria point to the potential utility in designating post-exertional malaise and fatigue, sleep dysfunction, pain, clinical neurocognitive, and clinical autonomic/neuroimmunoendocrine symptoms as major criteria.

The selection of diagnostic signs and symptoms has major implications for which individuals are diagnosed with ME/CFS and how seriously the illness is viewed by health care providers, disability insurers, rehabilitation planners, and patients and their families and friends. I hope the results of this comparison study will encourage more physicians to USE THE CANADIAN CLINICAL CRITERIA.

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The Canadian Clinical Case Definition has brilliantly rewritten the guidelines to capture, at last, what ME/CFS is really all about. It is not that patients are fatigued. Healthy people get fatigued. Rather the definition specifically selects patients who worsen with exercise. This takes the emphasis away from the subjective sensation of "fatigue" and forces one to clearly describe the connection between fatigue and activity. This also embraces mental fatigue (loss of cognitive function and alertness) as well as physical fatigue (lack of energy and strength, often felt in the muscles). The patient must become symptomatically ill after exercise and must also have evidence of neurocognitive, neuroendocrine, dysautonomic (e.g. orthostatic intolerance), and immune malfunction.

The Adelaide Forum agreed to UNANIMOUSLY EMBRACE THE CANADIAN CASE DEFINITION with a strong recommendation that it also be taken up by ME/CFS societies.

*(Excerpt from the review of the Adelaide Forum, Australia, 2005)*

**Michael Barratt, MBBS, FRCPA**  
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In my opinion, and in the opinions of the other doctors at the Environmental Health Clinic, the ME/CFS Consensus Document is EXTREMELY PRACTICAL AND USEFUL. We have used it repeatedly in helping to develop comprehensive individual treatment plans in collaboration with patients. At the behest of the Ontario College of Family Physicians' (OCFP) Environmental Health Committee, and with approval of the publisher, the consensus diagnostic checklists were posted on the OCFP website. We also use the diagnostic criteria, checklists, and treatment suggestions as teaching tools in the OCFP's Environmental Health Day at their Annual Scientific Assembly.

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## DEVELOPMENT OF THE CANADIAN CONSENSUS DOCUMENT

The National ME/FM Action Network of Canada spearheaded the drive for the development of an expert consensus document for Myalgic Encephalomyelitis / Chronic Fatigue Syndrome (ME/CFS). In response to increasing numbers of patients inquiring about doctors knowledgeable about ME/CFS, the Network sent a questionnaire to doctors across Canada asking what items would be most helpful in assisting them with their ME/CFS patients. The physicians concurred that a clinical definition, as well as diagnostic and treatment protocols were of prime importance.

The National ME/FM Action Network then approached two clinicians knowledgeable about ME/CFS and experienced in its diagnosis and treatment. Dr. Bruce Carruthers of British Columbia and Dr. Anil Jain of Ontario kindly agreed to co-author a draft document. Lydia Neilson, President of the National ME/FM Action Network, met with the Honourable Alan Rock, then Minister of Health, to discuss the results of the doctors' survey and the draft document. The Honourable Alan Rock responded by stating the draft clinical definition was "a milestone in the fight against this complex and tragic condition".

Health Canada established the "Terms of Reference". One stipulation was that at least one member of the panel must be nominated by each of the five stakeholder groups of government, universities, clinicians, industry, and advocacy. There had to be at least ten members on the panel, four of whom could come from outside of Canada. Panel members had to be practicing MDs actively treating and/or diagnosing ME/CFS, or MDs or Ph.Ds involved in clinical research of the illness. Their mandate was to develop a clinical

definition that addressed a broader spectrum of the pathogenesis of the illness, as well as to provide diagnostic and treatment protocols for medical practitioners. The members of the panel would have autonomy over their consensus document.

Health Canada selected an Expert Consensus Panel for ME/CFS. The eleven-member Expert Consensus Panel received more than forty nominations including numerous nominations from each stakeholder group. The members of the Consensus Panel represented clinicians, university medical faculty, and researchers in the area of ME/CFS. Collectively, the members of the panel had diagnosed and/or treated more than twenty thousand ME/CFS patients.

Health Canada planned for a Consensus Workshop to be held on March 30 to April 1, 2001. Crystaal (Biovail Pharmaceuticals) funded the workshop without having any involvement with or influence over the Consensus Document. They hired Science and Medicine Canada to organize and facilitate the workshop.

The draft document went through three rounds of revisions prior to the Consensus Workshop where the document received consensus, in principle, with directives for various members to revise some sections. The document was compiled by Marjorie van de Sande and the revised document was sent to the panel. There was 100% consensus by the panel members on the final Consensus Document<sup>1</sup>. The Consensus Document has become known as the "Canadian Consensus Document for ME/CFS".

### Importance of a Clinical Definition

The Greek origin of syndrome is *syn* - together, and *drome* - a track of running. One must determine the tracks of travel and observe the travel of a patient's syndrome components. Because research definitions define a static collection of symptom entities, they have ignored or downplayed the critical dynamic nature of this syndrome as lived by patients. The normal fatigue pain pattern already related to relational action and adapted by activity rest dynamics broken in ME/CFS. As a result there are cumulative physical and cognitive fatigue and crashing patterns, which are central to this clinical definition. The defective physical cardiac output abnormalities correlate with the degree of reactive fatigue and overall severity of ME/CFS. These findings could supply an objective marker for fatigue severity and debility, and help explain why ME/CFS can be so disabling. It is important for the clinician to observe the dynamics of the whole cluster of symptoms in their interaction, additive effects, and the disruption to patients' lives over longer periods of time.

