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I am a physician and attorney with 20 years of experience in the biotechnology and specialty chemical industries. I have also been a CFS patient for the last 20 years. I am currently a director of both the IACFS/ME and Epiphany Biosciences and have previously served as a director of other biotechnology and not-for-profit companies, including the HHV-6 Foundation.

This illness is at a critical juncture in its history both in terms of (i) major research findings that have the potential to transform the lives of millions, and (ii) the politics that could allow ground breaking research to blossom and flourish into game changing research.

Two studies reported over the last couple of months have brought us to this threshold:

1. The publication this month in *Science* of the detection of XMRV (xenotropic murine retrovirus) in CFS patients is a landmark study.
2. The presentation last month of the valomaciclovir trial at the ICAAC Conference (Interscience Conference on Antimicrobial Agents and Chemotherapy) marks the first in vivo demonstration of an anti-EBV effect of a drug in a phase 2, FDA-approved clinical trial.

In the valomaciclovir trial, the median EBV viral load in the saliva of patients treated with valomaciclovir was undetectable at the end of the treatment period and reached statistical significance with a p value of 0.002. Clinical course of illness was also significantly improved in the valomaciclovir group with a p value of less than 0.05.

The potential implications on EBV infectivity in infectious mono are obvious. With approximately 9-19% of patients progressing to meet criteria for CFS (Isaacs 1948; White et al 1998; Buchwald et al 2000; Hickie et al 2006; and Katz et al 2009), the design for the next valomaciclovir trial will include an assessment for incidence of CFS at 6 months post-symptom onset.

With sufficient levels of funding from public and private sources to pursue a comprehensive natural history trial in infectious mono, the next valomaciclovir trial would be able to include assays of XMRV, other viruses of interest and promising CFS biomarkers to gain a complete understanding of the early phases of CFS for the very first time.

Twenty-five years after the Lake Tahoe epidemic, we have finally built the foundation for CFS research to literally explode with innovative new findings, but for the absence of a productive research program at CDC and ample, dedicated research funding allocations from NIH.

The CDC's Five Year CFS Strategic Plan and the levels of CFS research funding at NIH are not just woefully inadequate. They are an embarrassment. But this wouldn't have to be the case if political will was exercised to make the necessary organizational and cultural changes at CDC

and NIAID (National Institute for Allergy and Infectious Disease). One of the most glaring deficiencies of past CDC stewardship has been the failure of the CDC to develop extensive collaborative relationships with extramural researchers. Worse yet, NIAID's research plan for CFS is virtually non-existent. A CFS research program housed in the Office of Women's Health is not a substitute for a robust CFS research program headquartered in NIAID.

The ideal clinical trial as described above that studies that natural history of infectious mono as it morphs into CFS would be the perfect opportunity for the CDC and NIH to develop an intensive, interventional, natural history study that would be truly transformative. Unfortunately, the leadership of the CDC and NIH when it comes to CFS is neither visionary, nor have they prioritized CFS research.

Mike Houghton, discoverer of hepatitis C, Lasker Award winner and Chief Scientific Officer of Epiphany Biosciences, recently asked me three questions:

1. Why don't CDC and NIH have programs that diagnose and monitor CFS patients to establish the characteristics of CFS in patients with an onset consistent with an acute infection?
2. Why aren't all available pathogen signature tests used by the CDC and NIH in this population to establish the infectious etiology?
3. Why hasn't the CDC and NIH monitored the virological and host signature status of at risk patients and compared the patients who resolve their infection to those who do not?

I had no answers for Mike to any one of these questions, except to say that a private foundation, the Whittemore Peterson Institute, has been working very hard to try to address your questions. This type of research program has been ongoing for many years for hepatitis C and HIV/AIDS and now needs to be applied to CFS in an expansive and systematic manner. Such a program requires tremendous resources and technical expertise. CFS patients deserve the same degree of scientific rigor that has been applied to the study of hepatitis C and HIV/AIDS.

This is our moral imperative. A Congressional investigation is long overdue to explore potential allegations of malfeasance or intentional misconduct at CDC and to explain why the CDC who has been continuously working on CFS research over the last 25 years has been unable to uncover what a private foundation spending less than \$2 million has been able to discover in two years.

The CFS leadership at the CDC and NIH has alienated a great number of CFS stakeholders. Let us seize this moment in history as it presents itself to us. The fruit on the vine could not be any riper. It is time for our government to finally do the right thing and serve its constituents, instead of itself. It is time for the CDC and NIH CFS research programs to be re-built from scratch, from the ground floor, with a new culture and with new leadership.