

Testimony

MD/ MPH/ person with CFS

Dear Sir/ Madam,

Thank you for attending this CFSAC meeting and for the opportunity to address you with my concerns.

I write to you as a physician, former medical researcher, and person who has been disabled by Chronic Fatigue Syndrome. I am encouraged that some progress has been made since last year and would like to thank Dr. Harvey Alter's group for their study; Dr. Thomas Frieden for looking for a new CDC leader experienced in CFS; Dr. Francis Collins for personally attending the recent NIH XMRV workshop; Dr. Michael Gottesman for meeting with people affected by CFS and their families; and the numerous behind-the-scenes officials/ staff for organizing the XMRV workshop and the CFSAC meetings. However there remains much to be done.

1. Increase collaboration with experienced non-governmental CFS researchers/ clinicians and patient groups. The recent discrepancies in XMRV findings between various research groups highlights not only the importance of laboratory techniques but also how subjects are selected. The studies with positive results used clinicians (Dr. Dan Peterson, Dr. Anthony Komaroff, Dr. David Bell, Dr. Paul Cheney) who had decades of experience diagnosing CFS to select their subjects. The negative studies generally did not. Since CFS is an ill-defined illness, it would make sense to involve experienced clinicians in subject selection, as is frequently done in studies of other medical conditions, rather than using community-based random digit dialing, as the CDC did, to select subjects. I understand the need for community-based studies but it needs to be supplemented by clinic-based studies.

Similarly, patients have the biggest stake in this research, their lives, and many are eager to volunteer for studies or help out in any way they can. Although patients and their families may seem to be a nuisance at times, realize that their true goal is not to make your life difficult but to get well. It's easy to lose sight of this – I know, I've been on the opposite side of the stethoscope. Tell us how we can help you work faster/ better and we will do what we can.

2. Perform a thorough review of the CFS research literature and incorporate past findings into current materials and future research. In a recent meeting with Dr. Michael Gottesman of the NIH, people asked Dr. Gottesman why this medical condition had been ignored for the last 2 decades. Dr. Gottesman replied that it was due to a lack of concrete scientific, clinical and medical findings. [1] This is not true but I am not surprised by Dr.

Gottesman's statement as it is representative of the mainstream medical and scientific community's ignorance. I might have said the same statement before I became ill.

There have been about 5,000 papers over the last 25 years documenting physiological abnormalities in multiple organ systems, including orthostatic intolerance, dysregulated immune functioning, aerobic metabolism issues, and abnormal SPECT/ fMRI scans. [2, 3, 4, 5] There are numerous past papers on the epidemiology of CFS. [6] However, little of this information, especially non-CDC study findings, has been discussed in CDC research papers or materials presented to the public within the last decade.

For example, materials directed towards health care professionals on the CDC website do not mention that outbreaks of CFS have been observed for many decades or that up to 80% of people who develop CFS start their illness with a flu-like illness. [7] Certainly, we do not know what these observations mean yet but it might help clinicians diagnosis patients more accurately and as early as possible. Clinicians might even think to ask patients if they have family members/ contacts with CFS, thereby adding to the knowledge base about the epidemiology of CFS. Healthcare professionals are no strangers to medical controversies but rather than discussing these topics and letting professionals make up their own minds these topics are not mentioned at all on the website.

In October of 2009, CFSAC recommended that AHRQ complete a review of CFS for an NIH State of the Knowledge Workshop. [8] I hope this is still being considered, that AHRQ does a thorough job, and that the CDC re-evaluates what they present as they are an influential agency. I have found much useful information from reviewing studies published by Dr. Leonard Jason, the International Association for CFS/ME, and the Journal of Chronic Fatigue Syndrome. Articles from these three parties are frequently not catalogued on Pubmed. Federal agency representative should also consider participating in the annual international conferences sponsored by various CFS research groups. Let's not re-invent the wheel here: use every bit of information available to solve this illness.

3. Investigate the long-term effects of CFS. Early studies examined whether CFS increased the risk of lymphoma [9]. Jason found, in a small study, that people with CFS died of cancer or heart failure at a younger age than people in the general population. [10] Young people, labeled as "crazy" and ill for years, have died with unexplained findings at autopsy including inflammation of the spinal dorsal root ganglions [11] and non-acute viral myocarditis [12].

The full recovery rate for CFS is less than 10% [13]; a 2009 survey by the CFIDS Association of America with 1,100 respondents showed that a large percentage of individuals had been sick for over 10 years. [14]. A few studies have reported on CFS outbreak subjects 10 years later but they have relied primarily on written questionnaires or subject interviews rather than medical record review or interview with the subjects' physicians. [15, 16] Subjective methods without confirmation may lead to an overestimation of improvement/ recovery and denial / downplaying of ongoing/ new symptoms. [17] In addition, CFS sometimes has a relapsing-remitting course such that many who believe that they have fully recovered find their symptoms returning years later.

Even though many questions surround CFS, do not let it delay research into this important topic. People are living with and dying of complications as we wait. If more were known about long-term effects, patients and clinicians might know what to watch out for and perhaps existing treatments could be used to prevent or ameliorate complications.

4. Establish 5 Centers of Excellence for CFS. This has been requested as a top priority by CFSAC to DHHS since at least September 2004. [18] Centers of Excellence or a similar structure are needed to carry out coordinated multi-disciplinary research, clinical care, and education of health care professionals. There are already several institutions carrying out CFS research that would be superb candidates, including the Whittemore-Peterson Institute and former CFS Cooperative Research Centers like the University of Miami. Furthermore, if MLV-related viruses turn out to play a major role in this illness, already established HIV Centers of Excellence might be adapted to include CFS research as well.

Encouragement should also be given to young or new investigators interested in CFS. I have heard from research/ clinical colleagues that they are reluctant to invest their time/ energy due to lack of funding and the still-held view by more senior colleagues that CFS is a psychological illness not worthy of scientific investigation. Other than establishing Centers and waiting for investigator-initiated applications, NIH should consider issuing a new Request for Application (RFA) for CFS, especially in light of renewed interest by researchers with the recent XMRV findings.

5. Look into adverse effects of graded exercise therapy (GET). Information about activity pacing and graded exercise therapy has been modified for the better on the CDC website over the last year. However, the CDC maintains a link to the United Kingdom's National Health Service program on GET. [19] Over the last decade, 34-82% of CFS sufferers surveyed in the UK have reported that GET has worsened their health, not improved it. [20] This is not unexpected given the physiological abnormalities that have been detected

with exercise. [21] Furthermore, adverse effects of GET in studies have not been tracked or reported as rigorously as they should be. [22] While GET programs in the US may be different from those in other countries, this information should be taken into account when writing clinical guidelines.

6. Deliver CFSAC recommendations to Secretary Sibelius and ask for a written response to the recommendations. I have seen CFSAC video casts where members have noted that there has been no response from DHHS on many of their recommendations. It is unclear even whether the recommendations have been read. This is an unacceptable situation. I do not expect DHHS to agree with all CFSAC recommendations but I do expect Secretary Sibelius or her representative (Dr. Howard Koh) to read through the recommendations and tell us yes, no, maybe, we need more information to make a decision, etc.

Patients understand that CFS is complex and that answers will not come easily but we want an honest effort and an appropriate response from our government. Please do your best! I want to get well and return to my work and my life. Thank you for your time and attention.

Sincerely, MD/ MPH/ person with CFS

REFERENCES:

1. Solomon R. Summary of Sept 7, 2010, meeting with NIH officials and CFS patients and families. <http://www.forums.aboutmecfs.org/showthread.php?7438-CFS-patients-and-families-deliver-strong-message-to-NIH-officials-on-Sept.-7-2010>. (Accessed 9/15/2010.)
2. Carruthers BM, van de Sande MI. Myalgic encephalomyelitis/ chronic fatigue syndrome: a clinical case definition and guidelines for practitioners. An overview of the Canadian Consensus documents. 2005. http://www.cfids-cab.org/MESA/me_overview.pdf. (Accessed 9/15/10.)
3. Cook DB, O'Connor PJ, Lange G, et al. Functional neuroimaging correlates of mental fatigue induced by cognition among chronic fatigue syndrome patients and controls. *Neuroimage*. 2007 May 15;36(1):108-22.
4. Van Ness JM, Snell CR, Stevens SR. Diminished Cardiopulmonary Capacity During Post-Exertional Malaise. *Journal of Chronic Fatigue Syndrome*. 2006; 14(2): 77-85.
5. Kennedy G, Khan F, Hill A, et al. Biochemical and vascular aspects of pediatric chronic fatigue syndrome. *Arch Pediatr Adolesc Med*. 2010;164(9):817-823.
6. Briggs NC, Levine PH. A comparative review of systemic and neurological

- symptomatology in 12 outbreaks collectively described as chronic fatigue syndrome, epidemic neuromyasthenia, and myalgic encephalomyelitis. *Clinical Infectious Diseases*. 1994 18(1):, S32-S42.
7. A.D.A.M. Chronic fatigue syndrome. http://adam.about.com/reports/Chronic-fatigue-syndrome.htm#adamHeading_5. (Accessed 9/15/10)
 8. CFSAC. Committee recommendations, October 29-30, 2009. <http://www.hhs.gov/advcomcfs/recommendations/10302009.html>. (Accessed 9/15/2010)
 9. Levine PH, Fears TR, Cummings P, et al. Cancer and a fatiguing illness in Northern Nevada--a causal hypothesis. *Ann Epidemiol*. 1998 May;8(4):245-9.
 10. Jason LA, Corradi K, Gress, et al. Causes of death among patients with chronic fatigue syndrome. *Health Care for Women International*. 2006; 27:615–626.
 11. Hooper R. First official UK death from chronic fatigue syndrome. June 2006. <http://www.newscientist.com/article/dn9342-first-official-death-from-chronic-fatigue-syndrome-.html>. (Accessed 9/15/10)
 12. Schweitzer, M. Testimony before CFSAC September 2005. http://www.hhs.gov/advcomcfs/meetings/minutes/cfsac050912_min.html. (Accessed 9/15/2010)
 13. Cairns R, Hotopf M. A systematic review describing the prognosis of chronic fatigue syndrome. *Occup Med (Lond)*. 2005; 55(1):20-31.
 14. CFIDS Association of America patient survey April 2009.
 15. Levine PH, Snow PG, Ranum BA, et al. Epidemic neuromyasthenia and chronic fatigue syndrome in west Otago, New Zealand. A 10-year follow-up. *Arch Intern Med*. 1997 Apr 14;157(7):750-4.
 16. Strickland PS, Levine PH, Peterson DL, et al. Neuromyasthenia and chronic fatigue syndrome in Northern Nevada/ California: a ten-year follow-up of an outbreak. *Journal of Chronic Fatigue Syndrome*. 2001; 9 (3/4): 3-14.
 17. Bell D. Fatigue with and without orthostatic tolerance. *Lyndonville News*. May 2010. <http://www.davidsbell.com/LynNewsV7N1.htm>. (Accessed 9/15/2010.)
 18. CFSAC. Committee recommendations. September 2004. <http://www.hhs.gov/advcomcfs/recommendations/09272004.html>. (Accessed 9/15/2010.)
 19. Centers for Disease Control and Prevention. CFS Toolkit – graded exercise therapy. July 2010. <http://www.cdc.gov/cfs/toolkit/get.html>. (Accessed 9/15/2010)
 20. Kindlon T. Adverse reactions to graded exercise therapy. May 2009. http://sacfs.asn.au/news/2009/09/09_20_adverse_reactions_to_get.htm. (Accessed 9/15/2010)
 21. Twisk FN, Maes M. A review on cognitive behavioral therapy (CBT) and graded exercise therapy (GET) in myalgic encephalomyelitis (ME) / chronic fatigue syndrome (CFS): CBT/GET is not only ineffective and not evidence-based, but also

potentially harmful for many patients with ME/CFS. *Neuro Endocrinol Lett.* 2009;30(3):284-99.

22. Larun L, McGuire H, Edmonds M, Odgaard-Jensen J, Price JR. Exercise therapy for chronic fatigue syndrome. *Cochrane Database of Systematic Reviews* 2009, Issue 1. (Updated from 2003, Issue 4.)