

Public Comment
CFSAC | December 2014
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Due to the very short time window to provide public comments and my health issues due to ME especially PEM/PENNE and managing through the majority of symptoms of ME plus POTS and FIBRO, this is the best I can do on my own to have it put on record. Pls note that I have major cognitive issues & didn't want my friend to make edits bc HHS does not seem to fully understand the debilitating nature of this disease.

This will be edited during the holidays after I rest and can help her make it into a 3 minute comment for CFSAC webinar if selected.

Thank You to our ME/CFS Experts:

First I want to thank all the ME/CFS experts that have dedicated their time in treating patients and research to help us have better lives. For me, it is not being completely bed bound but the majority of my time is home bound. Without you, the majority of ME patients would be gravely harmed and suffer immensely. In addition, the science about this disease would not have been advanced to this level without you. We are so grateful!

The Remaining of my testimony is targeted to HHS: 30 years of NEGLECT in regards to the name, the definition chaos, and the major flaws of AHQR Literature Review and P2P.

It's time for us to be critical, angry, and intolerant of your years of harm to our patient community. What has happened to ME patients is morally and scientifically wrong!

There are numerous problems with HHS' public health policy toward ME such as the name of the disease and the definitional chaos, lack of commitment, woefully inadequate research funding, outdated and downright harmful medical education and HHS's refusal to transparently engage the experts and patient community. ALL MUST BE ADDRESSED and corrected immediately **lead by our experts** partnering with HHS and must include patients & patient advocacy groups.

You have failed us for years. During my diagnosis process, I saw over 20 doctors that involved misdiagnosis, doctors screaming at me bc I was not compliant with medication in which I was, told I was stressed out bc of my age and I didn't have kids (in which I didn't want kids and definitely not stressed out!) so she gave me a piece of paper with stress management and yoga stretches – no clinical evaluation. I had MANY doctors roll their eyes at me when I told them I had CFS. I was sent to 2 psychologist and both send me back to the doctor with a clean mental health bill and told the doctors that I looked physically sick and if they could not help me, pls refer me to another doctor. I could give you tons of other examples.

Evidence Review Conducted by AHRQ on the Diagnosis and Treatment of ME/CFS
Reference: <http://www.occupycfs.com/2014/10/15/evidence-review-comments-preview/>

Most fundamentally, the Evidence Review is grounded in the flawed assumption that eight CFS and ME definitions all represent the same group of patients that are appropriately studied and treated as a single entity or group of closely related entities. Guided by that assumption, this Evidence Review draws conclusions on subgroups, diagnostics, treatments and harms for all CFS and ME patients based on studies done in any of these eight definitions. In doing so, the Evidence Review disregards its own concerns, as well as the substantial body of evidence that these definitions do not all represent the same disease and that the ME definitions are associated with distinguishing biological pathologies. It is unscientific, illogical and risky to lump disparate patients together without regard to substantive differences in their underlying conditions.

Compounding this flawed assumption are the *a priori* choices in the Review Protocol that focused on a more narrow set of questions than originally planned and that applied restrictive inclusion and exclusion criteria. As a result, evidence that would have refuted the flawed starting assumption or that was required to accurately answer the questions was never considered. Some examples of how these assumptions and protocol choices negatively impacted this Evidence Review include:

- **Evidence about the significant differences in patient populations and in the unreliability and inaccuracy of some of these definitions was ignored and/or dismissed.** This includes: Dr. Leonard Jason's work undermining the Reeves Empirical definition; a study that shows the instability of the Fukuda definition over time in the same patients; studies demonstrating that Fukuda and Reeves encompass different populations; and differences in inclusion and exclusion criteria, especially regarding PEM and psychological disorders.
- **Diagnostic methods were assessed without first establishing a valid reference standard.** Since there is no gold reference standard, each definition was allowed to stand as its own reference standard without demonstrating it was a valid reference.
- **Critical biomarker and cardiopulmonary studies, some of which are in clinical use today, were ignored because they were judged to be intended to address etiology, regardless of the importance of the data.** This included most of Dr. Snell's and Dr. Keller's work on two day CPET, Dr. Cook's functional imaging studies, Dr. Gordon Broderick's systems networking studies, Dr. Klimas's and Dr. Fletcher's work on NK cells and immune function, and all of the autonomic tests. None of it was considered.
- **Treatment outcomes associated with all symptoms except fatigue were disregarded, potentially resulting in a slanted view of treatment effectiveness and harm.** This decision excluded Dr. Lerner's antiviral work, as well as entire classes of pain medications, antidepressants, anti-inflammatories, immune modulators, sleep treatments and more. If the treatment study looked at changes in objective measures like cardiac function or viral titers, it was excluded. If the

treatment study looked at outcomes for a symptom other than fatigue, it was excluded.

- **Treatment trials that were shorter than 12 weeks were excluded, even if the treatment duration was therapeutically appropriate.** The big exclusion here was the rituximab trial; despite following patients for 12 months, it was excluded because administration of rituximab was not continuous for 12 weeks (even though rituximab is not approved for 12 weeks continuous administration in ANY disease). Many other medication trials were also excluded for not meeting the 12 week mark.
- **Counseling and CBT treatment trials were inappropriately pooled without regard for the vast differences in therapeutic intent across these trials.** This meant that CBT treatments aimed at correcting false illness beliefs were lumped together with pacing and supportive counseling studies, and treated as equivalent.
- **Conclusions about treatment effects and harms failed to consider what is known about ME and its likely response to the therapies being recommended.** This means that the PACE (an Oxford study) results for CBT and GET were not only accepted (despite the many flaws in those data), but were determined to be broadly applicable to people meeting any of the case definitions. Data on the abnormal physiological response to exercise in ME patients were excluded, and so the Review did not conclude that CBT and GET could be harmful to these patients (although it did allow it might be possible).
- **The Evidence Review states that its findings are applicable to all patients meeting any CFS or ME definition, regardless of the case definition used in a particular study.**

The issues with this Evidence Review are substantial in number, magnitude and extent. At its root is the assumption that any case definition is as good as the rest, and that studies done on one patient population are applicable to every other patient population, despite the significant and objective differences among these patients. The failure to differentiate between patients with the symptom of subjective unexplained fatigue on the one hand, and objective immunological, neurological and metabolic dysfunction on the other, calls into question the entire Evidence Review and all conclusions made about diagnostic methods, the nature of this disease and its subgroups, the benefits and harms of treatment, and the future directions for research.

As the Evidence Review states, the final version of this report may be used in the development of clinical practice guidelines or as a basis for reimbursement and coverage policies. It will also be used in the P2P Workshop and in driving NIH's research strategy. Given the likelihood of those uses and the Evidence Review's claim of broad applicability to all CFS and ME patients, the flaws within this report create an undue risk of significant harm to patients with ME and will likely confound research for years to come. These issues must be addressed before this Evidence Review is issued in its final form.

My signature on letter by patients providing full comments:

Reference: <http://www.occupycfs.com/2014/10/18/comments-on-p2p-systematic-evidence-review/>

Part 1:

addresses the issues with the Evidence Review's base assumption that all CFS and ME definitions represent the same disease or set of closely related diseases, and the analysis and conclusions drawn regarding diagnostic methods, accuracy and concordance of definitions, subgroups and diagnostic harms.

<https://dl.dropboxusercontent.com/u/57025850/Comments%20on%20AHRO%20Evidence%20Review%20Part%201of2%20Final.pdf>

Part 2:

addresses the analysis and conclusions drawn regarding treatment effects and harms; and issues related to applicability, reliability and future research directions.

<https://dl.dropboxusercontent.com/u/57025850/Comments%20on%20AHRO%20evidence%20review%20Part%202of2%20Final.pdf>

Stop the NIH P2P process is it seriously flawed and biased

In Oct 2012,

CFSAC voted upon and agreed for the following recommendation to be forwarded to the Assistant Secretary for Health and the Secretary: that you will promptly convene (by 12/31/12 or as soon as possible thereafter) at least one stakeholders' (Myalgic Encephalomyelitis (ME)/Chronic Fatigue Syndrome (CFS)experts, patients, advocates) workshop in consultation with CFSAC members to reach a consensus for a case definition useful for research, diagnosis and treatment of ME/CFS beginning with the 2003 Canadian Consensus Definition for discussion purposes.

However, HHS decided to take their own approach and disrespect our experts and the patient community. A Consensus of our Experts wrote to Secretary *Sebelius* as well as many patients. To no avail as usual. We were awarded IOM and P2P. Also, based on FOIA HHS is very confused on what is the difference of these to programs (IOM and P2P). That is a great concern for me because the info that is derived from these programs will affect MY LIFE not YOURS!

The following info Reference:

<http://www.occupycfs.com/2014/11/17/p2p-not-this-science/>

What disease our we studying ME or CFS – you can't study two separate diseases – this is a major flaw! I don't have CFS – I have ME include PEM!

The [P2P Workshop agenda](#) focuses on a few broad categories of ME/CFS research: characteristics of the ME/CFS population; fostering innovative research; presentation and diagnosis in clinic; and, tools and measures for diagnosis and outcomes. Yet even with the late addition of Dr. Mady Hornig to discuss the immune system and ME/CFS, the Workshop agenda still glosses over many topics in etiology, diagnosis and treatment. This “science lite” approach will hamstring the non-ME/CFS expert Panel, and practically guarantees deficiencies in the final Workshop report.

It doesn't have to be this way. The P2P approach stands in stark contrast to the science presented at the [2011 State of the Knowledge](#) meeting. That workshop dove deep into infectious disease, systems biology, immunology, neurology, exercise physiology, diagnosis and biomarkers, and treatments. While there was no panel to produce a set of recommendations, the meeting participants identified a number of opportunities for advancing ME/CFS research, including: define and standardize case definition and terminology; conduct more cross-system research; develop standard procedures and common data elements across the field; address gaps in study design, biomarkers and clinical trials, outcome measures, and reproducibility; create a centralized data repository; and attract new investigators. *All of these issues remain unaddressed and unsolved three years later.*

Of course, we need not look back three years for examinations of ME/CFS science and priorities. For example, the [May 2014 Invest in ME](#) conference focused on autoimmunity, infection, immunological biomarkers, brain imaging, the autonomic nervous system, markers for post-exertional malaise, and diagnostic and treatment strategies. Then there was the [March 2014 Stanford ME/CFS Symposium](#), which [examined](#) epidemiology, cytokine and gene expression patterns, cardiovascular aging, MRI and EEG findings, inflammatory/autoimmune profiles, and microbial investigations.

Finally, there was the [March 2014 IACFS/ME Meeting: Translating Science into Clinical Care](#). This four day meeting was even more comprehensive than the 2011 State of the Knowledge workshop, covering immunology, exercise and metabolism, treatments, orthostatic intolerance, pediatric issues, autoimmunity, biomarker and pathogenesis findings, case definition issues, brain function and imaging, and much more. There is a [detailed summary](#) available, as well as Dr. Komaroff's [conference summary talk](#).

Replication of these scientific meetings is not required, or even necessarily desirable, for ME/CFS experts to examine the field and identify research priorities. Each meeting should build upon and expand what came before. But of course, the P2P Workshop will not ask ME/CFS experts to do this.

The P2P Workshop will ask non-ME/CFS experts to identify future research priorities *without giving them all the necessary information to do so*. All along, we have been assured by Dr. Susan Maier (NIH), Dr. Beth Collins-Sharp (formerly AHRQ), and others that the non-ME/CFS expert panel will receive the evidence review survey of the literature and presentations by ME/CFS experts, and that the two combined will

adequately equip them to pronounce judgment on the future direction of ME/CFS research. But this is not the case.

The evidence review ignored or excluded the science on biomarkers, pathophysiology, some promising treatments, and the case definition conundrum. And the P2P Workshop agenda appears to be completely devoid of science on brain imaging, autoimmunity, orthostatic intolerance, and pediatric issues (to name a few topics). For example, Dr. Chris Snell is speaking about lessons from current treatments and clinical trials, not exercise abnormalities. If there is any discussion of cognitive dysfunction, it will only be because a speaker manages to shoehorn it into his/her talk.

How on earth can a panel of non-ME/CFS experts, presented with very limited information on the science and working over just a few days, produce recommendations for future research that will actually move the field forward? And if they manage somehow to do so, how will the recommendations be any different from what emerged from the 2011 State of the Knowledge Workshop?

I do not object to the use of non-ME/CFS experts in all cases or circumstances. I do not believe that this disease is too difficult for outsiders to understand. For example, the non-ME/CFS experts on the IOM committee have had the benefit of more than a year's immersion in the literature with eight experts in the room to provide perspective, and this will hopefully have a positive impact on the outcome.

But for the 100% non-ME/CFS expert Panel to grasp this complex and controversial knowledge base in the very limited time they have to produce their report is an extraordinary challenge. It would be a challenge even if they were thoroughly immersed in that knowledge base through the evidence review and Workshop. As should be abundantly clear, I do not believe they will be immersed in the knowledge base. The Panel has been given a fundamentally flawed and imbalanced evidence review (compiled and written by other non-ME/CFS experts). They will hear a narrow and skewed presentation of ME/CFS science at the Workshop, despite the inclusion of some highly qualified speakers.

The P2P Panel's report may not be our worst fears come to life, but there is a significant risk that it will not produce recommendations that will propel ME/CFS research forward – if for no other reason than the Panel will not actually be shown the full research landscape. How can you draw an accurate map if you don't actually see your starting point or the landscape through which you must navigate? The P2P situation is a bit like asking someone to chart a path from point A to point B, but not telling them about the 4,000 foot change in altitude in between, and also not giving them the proper footwear for the hike.

Other flaws:

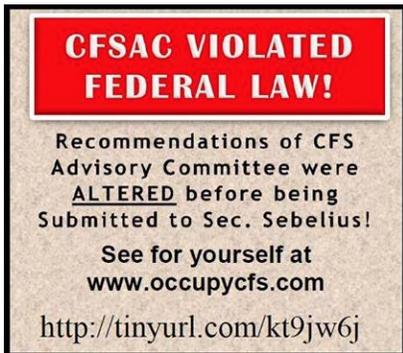
- discussion of Severe ME
- pediatric patients

- New study Montoya's study on brain and other studies currently being conducted by our experts

CFSAC Violation

Reference: <http://www.occupycfs.com/2014/11/24/another-cfsac-violation/>

After the recommendations from the March 2014 meeting were posted on the CFSAC website, Mary Dimmock and Denise Lopez-Majano noticed that something was wrong. The recommendations did not match what they recalled from watching the meeting. At first, we thought it was just the omission of references to the Canadian Consensus Criteria, but as I looked more carefully I found the changes went way beyond that.



Center of Excellence:

- Please approve based on our experts recommendations only. I WILL NOT endorse any program from HHS that does not follow their instructions. Currently, many patients are getting inadequate care due to the misinformation provided by CDC website and main stream doctors lack of knowledge in this disease. Many patients can't travel far to see the experts in their area. For example, I travel by train 2 hrs each way than have another 30 minutes each way to get home. No one locally will treat me. I have been on a mission to just get IV saline in my area and It has been 2 yrs. I finally found a doctor that was willing to help than Medicare and my prescription plan would not approve this treatment. Currently, I am trying to reach the appropriate personnel at Medicare to see what can be done since this is covered by many who have private insurance.

Medical Ethics and Humanity:

I was watching CSPAN one morning and I hear a discussion as summarized:

HHS was in attendance and in agreement at the 2014 International Conference of AIDS – that HUMINAITY is Key in the treatment and prevention of AIDS. Why? Bc 14 patients died in Australia. Well we had over 14 ME patients die this year or many gravely suffering with feeding tubes in their beds waiting to die! You need to understand that we may not be terminal. However, do you think it is medically ethical to allow patients to suffer in bed or homebound for year (7, 10, 20, 25 yrs). We don't want to be the living

dead. I would ask you to spend one month in your house resting. I have spent weeks in bed sleeping or just lying there to week to do anything. Is tis a LIFE? Is that morally right?

We are demanding: EQUALITY! It is our time NOW/Immediately. We ask for the same set of standards as you did for AIDS and many other diseases that we are just as debilitating or more. This is a wicked disease. Named ME not ME/CFS!

It's time for HHS to acknowledge ME under the case definition by the consensus of our experts. Our experts need to be respected and listened to as well as patients and not ignored by HHS who are not experts in this disease nor treat patients.

Provide us Funding NOW. It can be done.

I am tired of advocating the same issues over and over. It is time to have a PEACE TREATY and all parties come together to make critical changes so we have a chance at life and stop viewing the world from our windows and beds. It is critical to listen to our experts (consensus not your cherry picking of experts or one patient). It has to be experts with help from patients and patient advocacy group with support by our government – all in alignment. Otherwise, my hope is lost to have a normal life.

Sorry out of time – have to submit