Chronic fatigue syndrome

Committee for Science and Education, Medical Association of South Africa

Objective. To acknowledge the clinical syndrome chronic fatigue syndrome (CFS) and outline the diagnostic criteria and reasonable management.

Outcomes. Attempt at containment of treatment cost and improvement of the quality of care of patients with CFS.

Evidence. Delphi-type commentary from 20 expert clinicians and appropriate organisations. Limited literature survey.

Values. To clarify the reasonable management of CFS amid conflicting clinical opinion on a condition of concern to patients, funders and doctors. An adaptation of an existing guideline was sent to organisations and individuals for comment. Comments received were included in this guideline where possible.

Benefits, harms and costs. To acknowledge a clinical syndrome with a reasonable approach to management considering the cost implications. No cost analysis was done.

Recommendations. To recommend the following: (*i*) diagnostic criteria for CFS; (*ii*) potential differential diagnoses and possible investigations; and (*iii*) management protocol.

Validation. The draft guidelines were subjected to external review by individual doctors who are acknowledged CFS treaters, doctor groups and the patient support group. There were major disputes about the content, with the responses falling into two groups: those who do not believe CFS is a distinguishable illness, and those who do.

Developer and funding. The Committee for Science and Education, Medical Association of South Africa.

Endorsements. Medical Association of South Africa and national health care organisations (see list at the end of the document).

S Afr Med J 1995; **85:** 780-782.

Synonyms

Major controversy surrounds the name of the syndrome. In medical circles the preferred term is chronic fatigue

Committee Members: E. M. Barker (Chairperson), B. M. de Bruijn, E. J. Immelman, D. G. C. Presbury, A. D. P. van den Berg, D. A. Green, V. J. Pinkney-Atkinson

syndrome (CFS). Myalgic encephalomyelitis (ME) is a synonym used extensively outside South Africa, and the patient support group, the ME Association, has expressed the wish that the illness should be known as ME. The syndrome is also called yuppie 'flu.

Objective

To acknowledge the clinical syndrome CFS, and outline the diagnostic criteria and rational management.

Rationale

In 1993 the Committee for Science and Education of the Medical Association of South Africa considered the issues surrounding CFS and published a therapeutic guideline.[1] In the light of the MASA clinical guidelines initiative it was decided to review the guideline and submit it to external review by concerned groups and individuals. It is clear that CFS remains controversial and puzzling. While some doctors continue to deny the existence of CFS as a separate clinical entity, medical funders are inundated with claims relating to it. There was a major dispute surrounding the existence of CFS as a distinguishable illness. The MASA has a continual stream of enquires from doctors and patients asking for more information about CFS.

This revised guideline, in meeting the requirements for a MASA-endorsed guideline, has elicited comment from doctors, organisations and individuals concerned with the management of CFS on a daily basis. Their comments have been incorporated into the successive versions of the guideline and those who have agreed with the final version are listed at the end.

The background and history of CFS were documented by Spracklen.[2] Many patients and their caregivers are using complementary therapies, and some use potentially harmful interventions because CFS has no proven cure. The cost of unnecessary investigations and treatment is very high. The MASA believes that in the absence of adequate research studies this guideline represents a reasonable approach to the treatment of CFS.

Methods

The MASA guideline on CFS management was circulated to a select group of doctors and organisations for comment and endorsement using a Delphi-type methodology. The doctors were selected on the basis of knowledge about CFS and the organisations because their members are involved with the care of CFS. The ME Association of South Africa nominated some of the doctor respondents. The draft guideline was subjected to an extended period of external review commencing in November 1993 and continuing to July 1994.

Sixteen responses were returned and the comments were accommodated where possible in the final guideline. The endorsement list shows only those national or specialist groups involved with the care of CFS patients on a daily basis. The MASA funded the guideline project.

Case definition for CFS

The case definition is adapted from that of the Centers for Disease Control, Atlanta, Georgia.[3]

A case of CFS must fulfil:

- major criteria 1 and 2
- minor criteria (symptom and/or physical):
  either 6 or more of the 11 **symptom criteria** and 2 or more of the 3 **physical criteria;**
  or 8 or more of the 11 **symptom criteria.**

Major criteria

1. New onset of persistent or relapsing, debilitating fatigue or easy fatiguability in a person with no previous history of similar symptoms. The fatigue does not resolve with bed rest. It is severe enough to reduce or impair average daily activity to below 50% of the patient's premorbid activity level for a period of at least 6 months.

2. Clinical conditions that should be considered in the differential diagnosis and must be excluded include:

- malignant disease
- auto-immune disease
- infections (bacterial, fungal, parasitic, viral)
- neuropsychiatric disease
- endocrine disease (e.g. hypothyroidism)
- side-effects of a chronic medication or other toxic agent (e.g. chemical solvents, pesticides, heavy metals).

Minor criteria

Symptom criteria

To fulfil a symptom criterion, a symptom must have begun at or after the time of onset of increased fatiguability, and must have persisted or recurred over a period of at least 6 months (individual symptoms may or may not have occurred simultaneously). Symptoms include:

1. Mild fever — oral temperature 37,5 - 38,6°C, if measured by the patient — or chills. (Note: oral temperatures about 38,6°C are less compatible with CFS and should prompt investigations for other causes of illness.)
2. Sore throat.
3. Painful lymph nodes of anterior or posterior cervical or axillary distribution.
4. Unexplained generalised muscle weakness.
5. Muscle discomfort or myalgia.
6. Prolonged (24 hours or more) generalised fatigue after levels of exercise that would have been tolerated easily in the patient's premorbid state.
7. Generalised headaches (or a type, severity or pattern different from headaches in the premorbid state).
8. Migratory arthralgia without joint swelling or redness.
9. One or more of the following neuropsychological complaints: photophobia, transient visual scotomata, forgetfulness, excessive irritability, confusion, difficulty in thinking, inability to concentrate, and depression.
10. Sleep disturbances: hypersomnia or insomnia.
11. Description of the main symptom complex as initially developing over a few hours to a few days (this is not a true symptom, but may be considered as equivalent to the above symptoms in meeting the requirements of the case definition).

Physical criteria

These must be documented by a doctor on at least two occasions at least 1 month apart.

1. Low-grade fever: oral temperature 37,6 - 38,6°C or rectal temperature 37,8 - 38,8°C. (See note to symptom criterion 1.)
2. Non-exudative pharyngitis.
3. Palpable or tender anterior or posterior cervical or axillary lymph nodes. Lymph nodes greater than 2 cm in diameter suggest other causes. Further evaluation is warranted.

Laboratory and clinical investigations

Diagnosis rests on clinical findings and appropriate, cost-effective investigation to exclude other conditions that may produce similar symptoms. No investigation to establish the presence of, or previous presence of, any of the viruses popularly believed to cause the syndrome are of any clinical value.

Specific laboratory tests or clinical measurements are not required to satisfy the definition of CFS. The evaluation suggested below is designed to exclude the conditions listed in major criteria 2. If the results of any of these tests are abnormal the doctor should search for other conditions:

- serial weight measurements (weight change more than 10% in the absence of dieting suggests other diagnoses)
- serial morning and afternoon temperature measurements
- HIV blood tests: full blood count, ESR, serum urea, creatinine, sodium, potassium, magnesium, liver enzymes, rapid plasma reagin and thyroid-stimulating hormone
- chest radiographs
- urine tests using dipsticks.

The above investigations should only be pursued when CFS is reasonably suspected and major criterion 1 and sufficient minor criteria are met, and not in every tired or depressed patient.

Management guidelines

The Committee is unaware of any published evidence supporting the efficacy of the many therapies currently propagated. At least one publication points out the potential harm of the therapies.[4] The high rate of response to placebo (41% in one double-blind trial) confounds many of the anecdotal reports of dramatic improvement in response to some therapies.[5] The following guidelines are suggested for management:

1. **Rest.** Although the evidence for the efficacy of rest is anecdotal, it is almost uniformly accepted that it is beneficial. It should not be seen as a 'cheap' form of treatment. The cost of absenteeism to the individual and the employer is potentially substantial.
2. **Tricyclic and other antidepressants.** Although CFS is not depression, there is a growing body of anecdotal evidence that this therapy may be efficacious.
3. Non-steroidal anti-inflammatory drugs may be used to treat myalgia if indicated.
4. Lifestyle modification including diet, cessation of smoking and appropriate use of alcohol may be required.
5. **Patient support resource.** The ME Association of South Africa (PO Box 461, Hillcrest, 3650) is a patient support resource to which doctors may wish to refer patients.

The Committee feels that other forms of treatment should only take place in the context of an ethically approved scientific trial. It is acknowledged that other therapies may become acceptable as knowledge of CFS grows.

Developed and funded by: MASA Committee for Science and Education.

Groups and organisations endorsing the guideline: Association of Physicians of South Africa, Chronic Fatigue Clinic, Cape Town, ME Association of South Africa, Medical Association of South Africa, National Pathology Group, South African Society of Occupational Medicine.

REFERENCES

1. Science and Education Committee, Medical Association of South Africa. Chronic fatigue syndrome — therapeutic guidelines. *S Afr Med J* 1993; **83:** 152-154.
2. Spracklen FHN. Chronic fatigue syndrome (myalgic encephalomyelitis): myth or mystery? *S Afr Med J* 1988; **74:** 448-452.
3. Holmes GP, Kaplan JE, Gantz NM, *et al.* Chronic fatigue syndrome: a working case definition. *Ann Intern Med* 1988; **108:** 387-389.
4. Schön B. Tetracyclines in myalgic encephalomyelitis: fad or fact? *S Afr Med J* 1992; **82:** 3.
5. Straus SE, Dale JK, Tobi MB, *et al.* Acyclovir treatment of the chronic fatigue syndrome. *N Engl J Med* 1988; **319:** 1692-1698.

Accepted 2 Mar 1995.