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## Managing claims for chronic fatigue the active way

Swiss Re's UK Life & Health Claims team arranged a web-based discussion group with Professor Peter White to describe recent UK-based research into treatments for Chronic Fatigue Syndrome (CFS) in the PACE trial.

The PACE trial was chosen because CFS can be an emotive subject for claimants and assessors. The study's findings about optimal treatment provides food for thought for claims professionals who manage these cases.

### The PACE research and conclusions

The research is based on the largest trial to date of treatments for CFS patients. The trial aimed to formally test the safety and benefits of the four most commonly used therapies. The full paper and web appendix are available for anyone to download free of charge using the web reference [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(11\)60096-2/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)60096-2/abstract)

You will need to register with the Lancet but this is also free of charge.

The research team compared the benefits and harm of the "active rehabilitation" treatments of Cognitive Behaviour Therapy (CBT) and Graded Exercise Therapy (GET) with the "passive adaptation" treatment of Adaptive Pacing Therapy ("pacing"). People assigned to each of these treatment groups received Specialist Medical Care (SMC) in addition to the allotted therapy. A control

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group received SMC only.

In brief, the therapies can be described as follows:

- CBT addresses unhelpful thoughts and behaviours in relation to a fear or avoidance of engaging in activity and symptoms by collaborating with a therapist in a series of experiments with increasing physical and mental demands.
- GET engages people in a therapeutic programme to incrementally increase their participation in physical activity so as to reverse physiological deconditioning and exercise intolerance that has occurred as a result of avoiding activity.
- Pacing advocates that people adapt to the illness, by planning and pacing activity with rest so as to avoid exacerbations and restrict participation in activity to well within their energy limitations.
- SMC consisted of an explanation of CFS, generic advice such as avoiding extremes of activity and rest, advice on self-help, and medication directed at specific symptoms. Given that this was care offered to patients in secondary medical care, it does not equate with the usual care and advice provided by family doctors.

The research team measured a number of outcomes based on participant self-rating at the outset of the programme, at 12 weeks (which was mid-therapy), 24 weeks and 52 weeks. The measures specifically addressed:

- Fatigue
- Physical function
- Adverse events (i.e. any clinical change, disease or disorder), including deterioration in health
- Adverse reactions to the trial treatments
- Withdrawal from treatment
- Various other measures including walking ability and psychological scales, and satisfaction with treatment

The main finding was that both the active rehabilitation treatments (CBT and GET combined with SMC) resulted in greater reduction of patients' fatigue and larger improvement in physical functioning than "pacing" with SMC or SMC on its own. 60% made a clinically significant improvement in fatigue and physical disability, while 41% regarded their overall health as being "much better" or "very much better" after participation in CBT and GET. No differences in proportions of people who experienced adverse events, reactions or deterioration were seen between the treatment groups. This indicates that either CBT or GET, coupled with SMC, is a moderately effective and safe treatment for CFS.

Results for those in the group that received "pacing" with SMC were no different than for those receiving SMC alone, which surprised the research team. It had been hypothesized that provision of any therapy in addition to medical care, would have had a better outcome than medical care alone. It is thought that behavioural activation helps to treat the illness itself, whereas "pacing" (staying within limits imposed by the illness) only results in adaptation to the illness.

The key message is that pushing the limits in a therapeutic setting using well described treatment modalities is more effective in alleviating fatigue and dysfunction than staying within the limits imposed by the illness traditionally advocated by “pacing”. If a CFS patient does not gradually increase their activity, supported by an appropriate therapist, then their recovery will be slower. This seems a simple message but it is an important one as many believe that “pacing” is the most beneficial treatment.

It will likely take time before the general public and some medical professionals accept the findings of this research given that on average it takes seventeen years for research findings to influence clinical practice (Agency for Healthcare Research and Quality, 2011).

In the meantime, what can insurers and reinsurers do to assist the recovery and return to work of CFS claimants?

### Key takeaways for claims management

- Check that the diagnosis of CFS is correct. Misdiagnosis is not uncommon; one London CFS clinic reported that 50% of patients referred to them with a provisional or definite diagnosis of CFS, did not have CFS. If you have concerns, question the diagnosis and refer to an expert.
- It is likely that input will be required to change a claimant’s beliefs about his or her condition and the effectiveness of active rehabilitation. Funding for these CFS treatments is not expensive (in the UK, around £2,000) so insurers may well want to consider funding this for the right claimants. It may be important to establish that there are no significant obstacles to recovery before embarking on this approach.
- Check that private practitioners are delivering active rehabilitation therapies, such as those described in this article, as opposed to sick role adaptation. Don’t assume that the private provision of services is necessarily of any better quality than the public-funded health service.

A final point specific to claims assessment, and a question we’re often asked, is whether CFS would fall within a mental health exclusion, if one applies to a policy. The answer to this lies within the precise exclusion wording. If the policy refers to functional somatic syndromes in addition to mental health, then CFS may fall within the exclusion. If the policy doesn’t refer to functional somatic syndromes as well as mental health then it would be difficult to apply. The point made is that a diagnosis of Myalgic Encephalomyelitis or ME (a term often used colloquially instead of CFS) is considered a neurological condition according to the arrangement of the International Classification of Diseases (ICD) diagnostic codes whereas CFS can alternatively be defined as neurasthenia which is in the mental health chapter of ICD10.

There will be more web-based training offerings from the Swiss Re team in 2012. If you’d like further information about this CFS study or if you’re interested in receiving web-based training and would like to make suggestions about topics, please contact [Heather Sutherland](#) or [Amy Parker](#).

## REFERENCES

- *White, P.D. et al (2011) Comparison of adaptive pacing therapy, cognitive behaviour therapy, graded exercise therapy, and specialist medical care for chronic fatigue syndrome (PACE): a randomised trial. The Lancet. 377 (9768), 823-836*
- *Closing the Quality Gap: Revisiting the State of the Science Series: Quality Improvement Interventions to Address Health Disparities. Review Protocol, April 2011. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/clinic/tp/gapdisptp.htm> accessed on 16 February 2012*