CHRONIC FATIGUE SYNDROME

SUMMARY
OF THE TALK GIVEN BY PROFESSOR P K THOMAS CBE DSc MD FRCP AND DR S WESSELY BM BCh MRCP MRCPsych on 2.11.93.

AT A FULL BOARD MEETING HELD IN RICHMOND HOUSE IN THE PRESENCE OF THE RT HON NICHOLAS SCOTT MBE MP.

Professor Thomas:-

1. The term Myalgic Encephalomyelitis (ME) was introduced at the time of the epidemic in the Royal Free Hospital in 1955. There can be no doubt that this epidemic represented mass conversion hysteria. The epidemic was triggered by a small number of cases of genuine neurological disorder, such as MS or post infective acute disseminated encephalomyelitis. In 1962 when Professor Thomas started working in the Royal Free Hospital there were still a number of symptomatic cases. The dominant symptoms were weakness, fatiguability and muscle pain.

2. The cases now seen in the UK are a variety but one thing is certain they do not have Encephalomyelitis. This term means inflammation of the brain and spinal cord, for which there is no evidence whatsoever. Their symptoms are Myalgia, Fatigue and some Psychiatric symptomatology.

3. Fatigue is a symptom in a wide variety of conditions and it is vitally important to establish a precise diagnosis. Many cases have been labelled as having ME when the diagnosis on further investigation was found to be eg Myasthenia Gravis, Hypothyroidism, Brain tumour, Occult infection, Metabolic neuropathies etc.

4. There are different types of fatigue. Fatigue is the inability to maintain the necessary output of force by muscles. a). Peripheral Fatigue that is due to problems with the muscles themselves, the neuro-muscular junction or with the spinal cord.

   b). Central Fatigue refers to difficulty in maintaining an output of muscle force because of problems in the activation of the nerve pathways that run from the brain to the spinal cord.

c). Objective Fatigue is something that can be demonstrated by physiological recordings, which measure the declining force from the muscle.

d). Subjective Fatigue refers to the situation where the delivery of the required force cannot be maintained because of uncomfortable sensations, not in the muscles themselves but in an indefinable way that affects drive and motivation.

5. The features of the chronic fatigue syndrome are multifarious and variable between different parts of the world. They have also changed over time. Definition thus becomes a problem, however symptoms should have persisted for at least six months. This is arbitrary but it does exclude patients who have the fatigue that normally follows many acute illnesses.

6. The dominant symptom is FATIGUE, both mental and physical. They are unable to work and many spend most of the day in bed or resting elsewhere. They have great difficulty in undertaking even mild exercise. Careful studies, in particular by Professor Richard Edwards in Liverpool and by a group in Sydney, Australia have shown unequivocally that the fatigue these patients experience is SUBJECTIVE. That is they have no muscle weakness,there is no difference between normal and CFS subjects in the decline and recovery of muscle force/contraction.

7. The second important symptom is MYALGIA or muscle pain. Characteristically this follows exercise rather than occurring at the time, it is the same as the pain which is suffered by physically unfit people after exercise. These patients are not active and therefore experience post-exercise myalgia after quite mild activity. It is related to muscle damage during what is called eccentric contraction. MUSCLE BIOPSY shows no abnormalities other than those related to the effects of inactivity ie type 11 atrophy of muscle fibres. The symptoms of CFS are therefore NOT due to neuromuscular dysfunction.

8. MENTAL FATIGUE is associated with emotional disorder. All studies have emphasized the high rates of psychological disorder in patients with CFS. Major or minor DEPRESSION is the commonest, however the following occur as well, somatization disorder, anxiety, hypochondriasis, hyperventilation and a few hysterical conversion syndromes.There is no psychiatric disorder in 23% of cases. CFS IS NOT DUE TO MALINGERING. It must be pointed out that fatigue is a symptom of depression and can be the initial symptom of depression.

One feature that tends to distinguish patients with CFS from other patients with depression is a lack of self blame or self deprecation which is often a conspicuous aspect. Patients with CFS are desperate to find some reason outside themselves which has caused their symptoms.

9. CFS is NOT related to chronic viral infection, previous claims have been shown to be faulty.

10 Prognosis is not clearly understood and is determined by many factors, such as :- Psychological, social and cultural influences.
Certain factors are associated with a poor prognosis, these are:- long duration of illness, high emotional distress, illness beliefs eg viral persistence or muscle disease, and poor clinical management.

11 Clinical management MUST include identification of the underlying depression and persuasion of the patient to accept this explanation. It must be treated as it could lead to suicide.
ACTIVE management is important, with graded rehabilitation towards achievable targets. Graded exercise does and will help. Patient support groups do not help as they tell patients that at all costs they must avoid exercise as it will make them worse which is totally untrue.
There is no difference between ME and CFS except in the patient's belief.

Dr Simon Wessely:-

1. There is no evidence of primary muscle dysfunction ie it is not a neuromuscular disorder or a neurological disorder. There is no evidence of inflammation of the CNS. There is no evidence of hysterical or feigned origin to symptoms.

2. It is associated with high rates of psychiatric disorders which are well in excess of what might be explained as a reaction to physical illness.

3. There is little evidence that it is due to a persistent virus. The only infective association is that it may be triggered by the Epstein Barr virus. Post viral fatigue after other viral illnesses should not last longer than six months.

The prognosis for those who acquire the label of "ME" is at the moment poor. The only three prognostic studies conducted to date all suggested that poor prognosis, and failure to improve, is closely related to illness beliefs of a solely physical origin to symptoms.

5. It seems likely that the greater the disability, the more likely is the disorder to be associated with either misdiagnosed psychiatric disorder or poor illness management. Many are iatrogenic ie Doctors contribute in perpetuating the disease and its symptoms.

6. TREATMENT is difficult, extraordinary sensitivity is necessary. Great flexibility is essential in treating these patients, each case is different. It is a treatable disorder but its management is deplorable at present, the worst thing to do is to tell them to rest.
Rehabilitation is essential, exercise is good for these patients, prolonged inactivity causes adverse physical and psychological consequences.
Most cases can be expected to improve with time.

7. As regards benefits:- it is important to avoid anything that suggests that disability is permanent, progressive or unchanging. Benefits can often make patients worse.

Dr M McGrath
Secretary DLAAB