Guildford ME/CFS Support Group
(& West Surrey)

Newsletter

December 2015

Future dates

Open to all members and carers.

20th January 2016 (Wednesday) 11.15am The Seahorse
The Street, Shalford, Guildford, GU4 8BU
www.theseahorseguildford.co.uk

15th February 2016 (Monday) 7.30pm The Weyside
Millbrook, Guildford, Surrey, GU1 3XJ
www.theweyside.co.uk

16th March 2016 (Wednesday) 11.15am The Seahorse

Our group website updated

We have changed the look of our group's website: www.rescue.myzen.co.uk
Our previous blue version was somewhat suited to possible light-sensitivity of any reader but was perhaps dull and depressing. Our current version is based on white.

Although lengthy, a powerful video from Dr Leonard Jason has been added to the beginning page of the website.

The second UK ME/CFS research collaborative conference

Source: www.meassociation.org.uk/2015/10/global-mecfs-research-22-october-2015

Perhaps most famous ME conferences in the UK are the 'Invest in ME' conferences that have been detailing global biological research into ME/CFS for many years. However, last year the likes of 'Action for ME' and 'The ME Association' grouped together to form another research power who also hold annual conferences that detail their research.

I've selected a few key parts of the article. Please refer to the source for the full article.

Dr Charles Shepherd reports and reflects on the second UK CFS/ME Research Collaborative conference held in Newcastle on 13 and 14 October, 2015.

The conference attracted a large number of researchers from here and abroad, clinicians, medical students – four of whom were funded by the MEA – and charity representatives. The presentations, workshops and discussions concentrated on neuropathology, autonomic nervous system dysfunction, clinical trials, including Rituximab, patient-reported outcomes and sleep.

Especially encouraging was the high standard of research being presented, as well as the way in which we are moving forward with a biomedical model of causation that involves infection, immune system dysfunction – including cytokine involvement, and resulting in low-level neuroinflammation. This type of neuroimmune model of causation could explain some of the key symptoms in ME/CFS and in turn lead to effective forms of treatment.

Professor Stephen Holgate, Southampton University (pictured), opened the conference with some encouraging news about the Wellcome Trust (a major funder of medical research) and Arthritis Research UK (another research funder that is interested in some of the overlaps between inflammatory arthritis and ME/CFS) joining the collaborative and making a substantial financial contribution.

Professor Holgate referred to some of the key conclusions and recommendations relating to nomenclature, definition, and the need to make ME/CFS an inclusive diagnosis that were contained in the Institute of Medicine (IoM) report. He also welcomed the sometimes critical but constructive analysis of ME/CFS research strategy that was contained in the National Institutes of Health Pathways to Prevention report.

Taking this forward in the form of a 'Grand Challenge', Professor Holgate set out a number of research priorities which all key stakeholders involved in ME/CFS research must now address:

- Agreeing on a case definition for ME/CFS
- Subgrouping (phenotyping in medical jargon) people who come under the ME/CFS umbrella in order to develop what is now referred to as personalized medicine. Professor Holgate compared the situation in ME/CFS to asthma, which used to be regarded as one homogenous disease with one basic cause and treatment. Asthma is now recognized to be a very heterogeneous condition that involves at least six different molecular and cellular pathways, with differing phenotypes responding (or not responding) to different forms of treatment (mast cell stabilization for example).
- Collecting and banking biological samples – blood, post-mortem tissue etc…
- Identifying preventable and therapeutic targets for each subgroup

Professor Jose Montoya, Stanford University, USA, opened the first plenary session on neuropathology with an outstanding presentation that commenced with a one-minute silent tribute to his close colleague and friend Dr Martin Lerner, who had recently died. Martin Lerner had worked with Professor Montoya on a number of research studies, including the use of antiviral treatment.

Professor Montoya also referred positively to the impact of the Institute of Medicine (IoM) report and is a supporter of the new IoM diagnostic definition for ME/CFS (or systemic exertion intolerance disease/SEID as is being recommended in the report) because he believes that clinicians need a simple and accurate way of making a diagnosis. He believes that the new IoM definition, which emphasises post-exertional malaise and orthostatic intolerance, is preferable to the options – e.g. Canadian, Fukuda – that are currently available. Work from the Stanford group indicates that there is a strong (90%) concordance between Canadian, Fukuda and IoM definitions.

He then said that people with ME/CFS had been ignored and humiliated by the very people who were supposed to be helping them – the medical profession. In his own words…."I have a wish and a dream that medical and scientific research societies in the US apologise to their ME/CFS patients".

Turning to treatment, Professor Montoya described how the publication of a flawed clinical trial involving acyclovir back in 1988 had led to the view that ME/CFS was not caused by EBV infection and that antiviral drugs do not have any role in the treatment of ME/CFS. Despite this, he has been involved in a number of the clinical trials that have assessed the efficacy and safety of the antiviral drug valganciclovir. This is a treatment option – involving a lower dose than is normally used in other situations and over a prolonged period of time, at least 6 months, possibly much longer – that he now uses for some ME/CFS patients with considerable success. In addition to antiviral activity and reduction of latent HHV-6 replication, he believes that this drug may have immunomodulatory effects in ME/CFS as well (as it can decrease the level of white blood cells called monocytes and reduce microglia activation in mice).

[CS note: During the discussion that followed I pointed out that here in the UK antiviral treatment is not recommended by NICE – so antiviral drugs are seldom used in ME/CFS and very little interest has been shown in further research or clinical trials involving antiviral treatment. The ME Association has met with Roche, the pharmaceutical company that makes this drug, but we did not have any success in trying to set up a UK clinical trial. We clearly need an independent randomised placebo-controlled trial to assess the value of valganciclovir in ME/CFS.]

Professor Montoya then described some of the other research that his multidisciplinary group at Stanford are carrying out on a large group of ME/CFS patients, along with healthy controls, with the help of a $5 million anonymous donation. In particular:

- Immune function studies that are looking at the response to infection with various organisms. In particular, the role of immune system chemicals called cytokines, how the cytokine pattern changes over time (less or more than 3 years – the Hornig/Lipkin study), as well as daily fluctuations in cytokines relating to activity levels. To do so they can measure over 50 individual cytokines and have access to a cohort of around 200 ME/CFS patients and 400 controls. Proposed research at Stanford will also involve a detailed study of the role of NK cell status and function in ME/CFS.

- Virology studies examining the role of latent herpes viruses including EBV and HHV-6 and how low NK function may be maintaining HHV-6 activation in ME/CFS. Professor Montoya also referred to research involving Torque viruses. CS note: Torque teno virus is considered to be a relatively new global marker of immune function and the more immunosuppression occurs, the higher the level of torque viruses. Professor Montoya pointed out that torque viruses have been found to be lower in ME/CFS – adding further support to the role of immune system activation in ME/CFS.

- Neuroimaging studies looking at both grey and white matter in the brain – one of which has used diffusion tensor imaging, an MRI based technique that can visualize location, orientation and anisotropy of white matter tracts in the brain. This study has recently been published and described a very significant structural abnormality involving the right arcuate fasciculus. This structure contains fibres which connect different areas of the brain. The fibres are thicker in ME/CFS than in healthy controls and the inference is that nerve fibre transmission is therefore affected. The abnormality could turn out to be a diagnostic marker for ME/CFS.

- Genetic studies examining HLA characteristics in ME/CFS and a genetic predisposition to ME/CFS

Dr Øystein Fluge, University of Bergen, Norway gave a very thorough presentation covering the history of Rituximab in ME/CFS starting from how his group were first alerted to the possibility that this could be an effective form of treatment for at least a sub-group of people with ME/CFS back in 2004 right up to the completed and published phase 2 trial, and the phase 3 multicentre clinical trial (150 patients across 5 centres) that is now fully recruited and underway.

As previously reported, Rituximab appears to be a safe form of treatment in ME/CFS – the side-effects reported so far being upper airways infections, late-onset neutropenia, allergic reactions, and in some cases a worsening of ME/CFS symptoms.

Dr Fluge also spoke about the other clinical trial they are carrying out involving the immunosuppressive drug cyclophosphamide and some of the research they are doing looking at endothelial dysfunction in blood vessels in ME/CFS (endothelium is part of the blood vessel wall).

One of the poster presentations from Jopson et al at the University of Newcastle described the clinical trial of Rituximab in primary biliary cirrhosis – which also causes debilitating fatigue – that they are undertaking.

ME/CFS, Fibromyalgia and mitochondrial disorders: a comparison

Source: www.prohealth.com/library/showarticle.cfm?libid=21780

by Cort Johnson 8th November 2015

Chronic fatigue syndrome and fibromyalgia can cause so many symptoms that they can lead themselves to a variety of diagnoses. That's a problem, but it turns out that the sheer number of symptoms found in these disorders may be a clue. Not many diseases can produce such a rich broth of symptoms.

Those diseases that do, tend to have systemic (body-wide) impacts or effect the brain. They include such disorders as autoimmune diseases, post-viral syndromes, neurodegenerative disorders, the so-called functional syndromes (FM, ME/CFS, etc.) and some mood disorders.

What about mitochondrial disorders? Hundreds of mitochondrial diseases exist, but many do have systemic effects. In fact, the United Mitochondrial Foundation (UMF) recommends that doctors think "mitochondrial disease" when three or more organ systems are affected. The Foundation also lists "CFS-like illnesses' as possible indicators of a mitochondrial disease.

The UMF's 40-plus mitochondrial disease symptom list is a long one and ranges from blindness to migraines to fainting. Because so many mitochondrial diseases exist, it's impossible to strictly compare the symptoms of "mitochondrial disease" to those found in ME/CFS and FM. We can, however, look at general symptom patterns.

Let's look at how the symptoms in mitochondrial diseases and ME/CFS and FM compare.

Symptoms

Exercise intolerance

It's perhaps not surprising that people with mitochondrial diseases often exhibit exercise intolerance. If the mitochondria – the energy producers in our cells – aren't working well, then our muscle cells are not going to be able to produce the energy we need to exercise.

People with mitochondrial disorders tend to be able to exercise only in a limited fashion. Fatigue is not necessarily always present, but fatigue and weakness often come quickly once activity is initiated and rest is needed to build up energy levels again. After rest, often no clinical evidence of weakness is present.

Weakness – the inability to generate force – is an important symptom. Weakness is different from fatigue. Fatigue is a sensation associated with pain, weariness, etc. One can feel fatigued without being weak.

I'm unclear on the status of weakness vs fatigue in ME/CFS. Most studies suggest weakness is not present but the two-day exercise studies suggest that the inability to generate force after exercise, i.e. weakness, is a major issue.

According to MitoAction, exercise and physical activity were not recommended for mitochondrial disorders in the past because of concerns about cellular muscle damage. Now, exercise in small amounts is recommended in order to avoid deconditioning – which reduces mitochondrial density – and to increase mitochondrial and blood vessel density, enzymatic activity and improve quality of life.

Post-Exertional Malaise (PEM) or Relapse (PER)
Post-exertional malaise or relapse is a major problem in ME/CFS and FM, and it occurs in people with mitochondrial diseases. Whether they experience the same kind of PEM that people with ME/CFS or FM experience, however, is unclear. (It is not at all suggested that people with ME/CFS and FM all experience the same type of PEM.)

The “global fatigue” people with mitochondrial disorders can experience after exertion, which causes slowed thinking, confusion and in some “an unmasking of behaviours normally under control,” sounds very much like ME/CFS and FM.

The muscle symptoms after exercise (pain, cramping and/or muscle spasms with or without tenderness and/or feelings of heaviness (cement legs), particularly in the muscles used) bear some similarities.

The quick appearance of muscle pain in Mark Vink’s legs after very mild exercise appears to be highly suggestive of mitochondrial problems. My symptoms after too much walking, on the other hand, tend to be less specific and more global. They include fatigue and burning pain sensations across my body, but my legs are not particularly affected.

The small muscles can be affected in mitochondrial disorders as well. Too much writing, for instance can cause penmanship to suffer. Tachycardia – rapid heartbeats – can occur. Blurred vision can be caused by eye muscle fatigue. (There’s no mention of the “floaters” often seen in ME/CFS.)

Other symptoms
Signs of significant autonomic dysfunction appear to often be found in both mitochondrial diseases and ME/CFS/FM. They include rapid or slowed heartbeats, problems standing, heat or cold intolerance, unusual sweating, spontaneous pallor or flushing or mottling and gut and bladder problems. Whether these symptoms worsen after exercise was not clear.

Sleep problems including sleep apnea, unrefreshing sleep and daytime fatigue are common in mitochondrial disorders and ME/CFS and FM. Not surprisingly, so is emotional distress.

Breathing problems can be found in both. Dr. Natelson has found that hypoventilation – a short, rapid breathing pattern – is fairly common in adult ME/CFS patients. Breathing problems tend to show up first in mitochondrial disorders during periods of increased oxidative stress (infections, following exercise or emotional distress) but can become more permanent over time.

They appear to be caused by the same problem that’s been suggested by Staci Stevens for ME/CFS – fatigued respiratory muscles in the chest and diaphragm. Staci Stevens has noted that the respiratory muscles are among the most active in the body.

The tendency for infections to cause long term fatigue that remains after the infection has been resolved occurs in mitochondrial diseases, and is, of course, reminiscent of ME/CFS. It suggests that an autoimmune process affecting the mitochondria could be triggered by an infection in ME/CFS or FM.

It’s clear then that major symptoms found in ME/CFS – fatigue, post-exertional malaise, sleep and cognitive issues – are also found in mitochondrial disorders. While muscle spasms and pain can occur in mitochondrial disorders, they don’t appear – at least from this overview – to achieve the kind of prominence found in fibromyalgia.

Mitochondrial diseases or Mitochondrial dysfunction?
Both symptoms and several study findings suggest mitochondrial problems may exist in ME/CFS and FM. If they do, it's not clear if a "mitochondrial disease" is present, i.e., if the mitochondria themselves are defective, or if mitochondrial function is being inhibited due to other factors such as insufficient oxygen and blood flows.

Mitochondrial diseases that are genetic in origin usually show up early in life but mitochondrial diseases can also be triggered later in life by infections, autoimmune processes, drugs or "other environmental factors." Epigenetic processes that affect the expression of mitochondrial genes over time may play a role as well.

One process that could be occurring in ME/CFS involves the blood vessels. Dr's Fluge and Mella suggest that autoimmune processes may be reducing blood flows and possibly impairing mitochondrial functioning.

A disease also does not have to be considered a "mitochondrial disease" for the mitochondria to be affected. The United Mitochondrial Disease Foundation states that evidence of mitochondrial dysfunction can be found in many diseases, including Alzheimer's and Parkinson's, amyotrophic lateral sclerosis (ALS), multiple sclerosis, Sjogren's Syndrome, lupus, rheumatoid arthritis, mental retardation, deafness and blindness, diabetes, obesity, cardiovascular disease and stroke.

For the complete article please refer to the source website:
www.prohealth.com/library/showarticle.cfm?libid=21780

The chokehold that behavioural treatments have on ME/CFS

Source: www.cortjohnson.org/blog/2015/11/11/chokehold-behavioural-treatments-chronic-fatigue-syndrome/

by Cort Johnson 11th November 2015

The lack of validated treatment options for ME/CFS are well-known. No drugs have been approved by the FDA in 30 years, and only one has made it through the FDA pipeline. None appears to be under development.

Chronic fatigue syndrome (ME/CFS) is a disease that affects at least a million people in the US. Studies indicate that it impacts functioning and quality of life at least as much if not more than major diseases such as multiple sclerosis.

The IOM committee stressed that chronic fatigue syndrome is a "serious illness that requires timely diagnosis and appropriate care."

Appropriate care can only take place, though, when the full range of treatment options are present and affordable (i.e. covered by insurance). Those two factors require that large, rigorous treatment studies take place.

Non ME/CFS experts stick to treatments that have been validated in clinical trials and passed down to them by treatment reviews. The options most people with ME/CFS are left with reflect the options that the "treatment marketplace" has opened for them.

The availability of those options are largely dependent on funding. Parties that are willing and able to fund large clinical trials can get their treatment out to practitioners. Small, unreplicated clinical trials, on the other hand, get almost no attention. Large funders, therefore, generally define the treatments options most doctors are aware of, and most patients get.

The few patients with the access and the money needed to see ME/CFS experts gain access to a wide range of treatments. These specialists use research findings and their experience to develop own unique treatment protocols – which are rarely covered by insurance.

The vast majority of people with ME/CFS are, except for generic symptomatic treatments, restricted to treatment options that have been validated in treatment trials. Let's see what the treatment marketplace has provided for them in the past three years.

Survey

In an attempt to assess what the "treatment marketplace" is providing for people with ME/CFS, I went through around 1,000 citations dating back to the beginning of 2013 and plucked out those that had to do with treatment.

I included every kind of treatment study, big or small, rigorous or not, or any analysis of a treatment study, or any description of a treatment study, as well as treatment reviews.
I broke the treatment citations up into behavioural/exercise and non-behavioural categories and determined the country of origin of each. I also examined the study size of some studies.

Results

69% of the citations referred to behavioural, exercise or pacing studies and 31% referred to non-behavioural studies.

Behavioural studies

CBT and CBT/GET studies dominated behavioural regimen with 71% of the citations referring to these studies (sometimes in combination with another treatment regimen such as the Lightning Process.)

Country of origin

Over two-thirds of the behavioural studies originated in two countries — the United Kingdom (22) and the Netherlands (14). Other countries:
US = 5, Belgium = 4, Norway = 3, Australia = 2, Spain = 1, India = 1, Japan = 1.

Non-behavioural Studies

About 30% of the treatment citations referred to non-behavioural studies. Most of these studies, even if successful, have little chance of making into the treatment lexicon for ME/CFS. This is because these studies lack replication (validation), are mostly small, and many come from countries with smaller research programs and thus are probably not respected.

In contrast to the behavioural studies no types of studies and no countries dominated the non–behavioural citations. The wide spread of studies in this category (22) has implications – if studies are not replicated they won't make it into treatment reviews for doctors.

With only one type of non-behavioural treatment, acupuncture, being assessed in more than one study, few of these treatment options have a chance of going mainstream. (CBT/GET studies showed up in 38 citations). The countries that dominated the behavioural studies (n=36) – the UK and the Netherlands – showed a distinct preference for the types of studies they wish to fund; they produced only three non-behavioural studies.

Critical factors

The Federal funding imbalance

I wasn't able to ascertain the source of the funding for the CBT/GET studies in the UK, the Netherlands and elsewhere but without a commercial product such as a drug being involved the funding presumably came from government sources.

The implications of two governments focusing substantial funding on one treatment type is clear: a dramatic restriction of the possible treatment options recommended for doctors and ultimately for most patients. Few of the treatments ME/CFS experts use showed up in this survey and few of which are available to patients seeing non-experts.

When a slim portion of the possible treatment options for a disease gets outsized attention three things happen: that treatment gets an undue focus in the media, doctors and patients treatment options are limited, and patients miss possibilities for treatment.

The importance of federal funding in a disease like ME/CFS which is not being courted by pharmaceutical companies cannot be understated. Few funding sources for large, effective clinical trials exist other than federal funders.

The critical role federal funders play can be seen in Rituximab. The one large study underway (in Norway) is receiving significant federal support. No studies are underway in countries that are not providing federal support.
In the U.S., the National Institutes of Health frequently funds clinical trials including Rituximab trial on myasthenia gravis. Despite clear indications that two drugs, Rituximab, and Ampligen, are helpful in ME/CFS no NIH-funded trials are underway. With Rituximab going generic and Hemispherx Biopharma unable to fund a large trial no trials are underway for either in the U.S..

So long as federal funders in the U.S. and elsewhere balk at supporting clinical trials for ME/CFS and the U.K. and the Netherlands are willing to pump large sums into their behavioural trials, it's hard to see how those treatment options will not continue to predominate in ME/CFS.

Study size
The difference in study size and country of origin in behavioural and non-behavioural treatments is dramatic. Study size tends to be high for behavioural studies and low for non-behavioural studies. High study size means increased validation plus the ability to ferret out more moderate treatment effects.

With nil or low participation from federal funders and drug companies many of the non-behavioural studies are small, lack rigor and are underpowered. Of the six drug trials over the past three years, for instance, only two had over 30 participants and two had less than five. Compare that with the number of participants in the most recent behavioural studies produced by two prominent behavioural practitioners, Bleijenberg (Netherlands) and Chalder (UK)
Number of Patients in Treatment Trials

- Bleijenberg – 244, 204, 142, 169, 112, 261, 120+,
- Chalder – 481, 641, 389, 1643, 9

Country of origin
Whether a study originates in a country with a large, established and respected research establishment or another country matters. The eleven non-behavioural studies from Turkey, Serbia, Italy, Korea and China will be valued less than studies originating in the U.S., the U.K. or Australia. Almost half the non-behavioural studies originated in a country that commands lesser respect. Virtually all the behavioural studies, on the other hand, took place in countries with more respected research entities.

Conclusion
The treatment options available for most people with chronic fatigue syndrome are not a function of the treatment possibilities present. Instead, they are largely constrained by which party is willing to commit the money needed to produce large, well-replicated studies that make it out to their doctors.

Symptomatic treatments to help with sleep, pain are available to many people with ME/CFS but when it comes to targeted treatments for their disease behavioural therapies often top a very short list of treatment options. The dominance of the behavioural therapy regimen in ME/CFS is the result of two factors.

One is the unwillingness of federal funders such as the NIH to fund research that will reveal viable treatment targets for drug manufacturers. This poor research funding has left ME/CFS a biological mystery. This has opened the door, as has happened so many times to so many diseases over time, to a behavioural interpretation of it.

The willingness of federal funders in the UK and Europe to pump large amounts of money into the behavioural treatment trials has effectively exploited that opening. A significant portion of the medical profession either accepts a behavioural interpretation of ME/CFS or has little or no knowledge of other possible treatments.

The behavioural/non-behavioural treatment divide has been exacerbated by the dominance of large, replicated behavioural studies from more respected countries and smaller, unreplicated non-behavioural studies, many of which are from less respected countries.
The solution is having federal funders in the US and elsewhere fund ME/CFS research to identifying biomarkers and ME/CFS clinical studies. Successful Rituximab and Ampligen studies would provide a significant counterweight to the ongoing (and seemingly never ending) drumbeat of behavioural trials emanating from across the Atlantic.

The upside of the attention given to CBT/GET is that the studies have drawn the attention of outside reviewers. Overviews have found them to have only moderate effects on fatigue and no effects on functioning. That suggests their influence could be eroded by well-designed trials that have more positive results.

Until those studies are done federal funders from the UK and the Netherlands will largely be able to dictate the treatment regimens available in doctors offices and few people will have access to the wide range of treatments that might help them.

Funding Rituximab and Ampligen trials in the U.S. would be a good first start for the NIH.

Online petition: misleading PACE claims should be retracted

Source: http://my.meaction.net/petitions/pace-trial-needs-review-now

TO: THE LANCET, PSYCHOLOGICAL MEDICINE, AND THE AUTHORS OF THE PACE TRIAL

Given the weak and flawed methodologies of the PACE trial, which claims that CBT (cognitive behavioural therapy) and GET (graded exercise) led to the recovery of ME/CFS patients, we, the undersigned patients, doctors, scientists, parents, children, family, friends, caretakers and #MEAllies:

– call upon The Lancet to retract the claim made in its February 2011 editorial [1] that 30% of patients, or indeed any patients at all, were said to have recovered in the accompanying Lancet paper on the PACE trial [2]; and retract from that paper all analyses and statements in relation to the absurd “normal ranges” for fatigue and physical function;

http://www.meaction.net/whats-wrong-in-the-lancet

– call upon Psychological Medicine to retract the claims in this paper [3] that 22% of patients in the CBT and GET groups recovered, based on recovery criteria that were weakened so far from their original form in the study protocol that they no longer represent recovery by any rational standard;

http://www.meaction.net/whats-wrong-in-psychological-medicine

– call upon the study authors to publish the recovery outcomes according to the analyses specified in the trial's protocol [4] and to give independent researchers full access to the raw data (anonymised by removing trial identifiers and all other data superfluous to the calculation, such as age, sex or location). #MEAction undertakes to meet any reasonable cost of analysis or data preparation;

http://www.meaction.net/why-the-pace-trial-authors-should-publish-the-planned-recovery-analyses/

- call upon all parties to reject the view that being as disabled as patients with congestive heart failure is a good recovery of physical function in CFS.

Why is this important?

The UK's £5 million PACE trial has been hugely influential in bolstering the view that CFS (chronic fatigue syndrome) patients can recover if they gradually increase their activity, despite widespread reports of harm [5]. This view informs how patients around the world are treated in the media, in medical practice and by society. It is crucial that misleading claims of recovery do not stand.

"All the issues with the trial are extremely worrying, making interpretation of the clinical significance of the findings more or less impossible." – Emeritus Professor Jonathan Edwards of University College London

Claims have been made in The Lancet and Psychological Medicine that a substantial proportion of CFS patients in the PACE trial recovered after a course of cognitive behavioural therapy (CBT) or graded exercise therapy (GET). However, the claims are based on criteria that were revised after the study was already underway.

These new criteria included "normal ranges" for fatigue and physical function that are so broad that patients could at the end of the trial have physical function similar to someone with congestive heart failure — and yet be classed as "recovered".

Being as disabled as patients with congestive heart failure [6] simply isn't good enough to count as recovery of physical function for patients with chronic fatigue syndrome.

READ MORE:
http://www.meaction.net/background-to-the-petition/

[1] http://bit.ly/1Rexu6L [2] http://bit.ly/1PUEyHm [3] http://1.usa.gov/1iioqBz

[4] http://bit.ly/1PRcpBK [5] http://bit.ly/1Mtu8yM [6] http://1.usa.gov/1iioXDC

Editor's note: We use here the term "Chronic Fatigue Syndrome" (CFS) in line with the PACE trial authors' terminology and use of the Oxford Criteria.

Crimson crescents facilitate CFS diagnosis

Source: www.immunesupport.com/93sum007.htm

By Robert B. Marchesani. Infectious Disease News, November 1992

The following article is quite old, 1992, but Crimson Crescents are part of modern day diagnostic criteria for ME/CFS, specifically the Canadian Criteria. I read that they can also appear in people with Lyme disease and Lupus.

MINEOLA, NY—A new physical finding in chronic fatigue syndrome patients may finally give clinicians what they have only dreamed about a clinical way to diagnose the disease.

Burke A. Cunha, MD, discovered what he called crimson crescents in the mouths of 80% of his CFS patients. After the word got out, Cunha received calls from other parts of the country. Physicians began telling him that they also were finding the crimson crescents in their patients once they looked for them.

"When we look inside somebody's mouth, infectious disease doctors and internists instinctively go right to the back and look at the pharynx. When they do that, they miss these crimson crescents because they are on the side. People have missed them for years," said Cunha, MD, chief, infectious disease division, Winthrop-University Hospital, Mineola, N.Y.

For the first time physicians may have a specific indicator to look for on physical examination of chronic fatigue syndrome patients, not unlike the bull's eye of erythema chronicum migrans in Lyme disease patients.

"If your patient has crimson crescents, you now can say it is probably chronic fatigue syndrome," Cunha said.

Cunha' s crimson crescents are located on both sides adjacent to the back molars. (See figure.) They are present as a crescentic membrane of tissue that points toward the uvula. During a tonsillectomy that membrane is removed, which is the anterior pharyngealpillar. This area is crimson-purple and looks like a crescent moon chopped in half because the base goes into the tongue. The top of the crescent bows in toward the middle such that each side mirrors the other, Cunha explained.

When someone has a tonsillectomy, the borders of the crescent become less distinct and the margins are not as sharp. They are located posteriorly where the tonsil would have been before it was taken out. So even patients who had their tonsils removed still present with the crescents but the location and appearance are modified, according to Cunha.

They are always bilateral, and they can be very bright, which is why he called them crimson instead of purple. These crescents last for months and gradually fade as the disease goes into remission. When the patient gets sick again, the crescents usually get redder.

"In chronic fatigue you always find the crescents alone. The rest of the pharynx is uninvolved," he said. There is a small portion of the normal population that may also present with these crescents. "If you get a patient with a sore throat in the office, he or she can have crimson crescents, and the back of the throat is red," Cunha said.

Cunha found crimson crescents in 3% to 5% of non-chronic fatigue patients who presented with non-specific sore throats. Patients who present with mononucleosis or Group A strep do not have the crescents, nor do those with cytomegalovirus pharyngitis or the common viral pharyngitis, according to Cunha.

After seeing many patients in a chronic fatigue study center at Winthrop Hospital, Cunha has his own beliefs about the etiology of CFS. "I believe that the virus that causes chronic fatigue comes from young adults or children who give it to adults. The young child recovers from the illness but the young adult gets a sore throat and some go on to develop the chronic fatigue in adults.

I do not know why, but that intrigues me," said Cunha who is also professor of medicine at the State University of New York at Stony Brook Health Sciences Center School of Medicine.

Cunha is trying to grow virus out of these crescents in an attempt to discover their cause. "The problem is when anyone does antiviral throat cultures, clinical labs are not equipped to grow HHV-6. In addition, with viruses you have to go deeper than just the surface because they live within cells. So my next step is to biopsy the crescents," Cunha said. Since there is no test for CFS, the physician must infer the disease from other sources.

"But the most consistent lab evidence that we look for are elevations of coxsackie B-titers and elevations of HHV-6 titers in combination with the decrease in the percentage of natural killer T cells," Cunha explained.

"If the patient has two or three of these abnormalities in our study center, then he or she fits the laboratory criteria for chronic fatigue. Nearly all patients with crimson crescents have two out of three of these laboratory abnormalities," he said.

Cunha's finding is especially promising for physicians who practice too far from a lab to get such evidence. "If you are a physician out in the middle of nowhere and you can't get HHV-6 titers and you can't get the natural killer-cell percentage, then the crimson crescents may be the only way besides history that can suggest the diagnosis," Cunha told Infectious Disease News.

This article was reprinted by The CFIDS Association of America, Inc. publisher of The CFIDS Chronicle 800/44-CFIDS by permission of Infectious Disease News. Volume 5, Number 11, November 1992.
