Chronic Fatigue Syndrome and PNIS
Edited and reviewed By Professor of Medicine William Nelson

IMUNE

International Journal of the Medical Science of Homeopathy

Question: What are the current views about chronic fatigue syndrome?

Duke psychiatrist Dr. Veeraindar Goli replies:

The very mention of chronic fatigue syndrome (CFS) strikes dread into the hearts of even the most seasoned clinician. It is difficult to find physicians willing to treat patients with CFS and managed care companies willing to pay for their care. This frustration is shared by patients and clinicians alike.

Numerous studies with fatigue as a prominent feature have been described in the literature since time immemorial. Yet CFS continues to be relegated to the grab bag of vague and poorly understood syndromes that do not fit the traditional allopathic model of illness with specific etiology and pathogenesis. Despite our skepticism (and perhaps ignorance), this condition, with its uncertain etiology, chronic nature, and unproven therapies, very much remains a disabling illness that strikes thousands of Americans and carries a poor prognosis that worsens with age.

Categorizing syndromes like this is like trying to fit a square peg into a round hole. Perhaps we need to broaden our perspective to incorporate a mind-body model to explain such complex disorders.

What is CFS?

Also known as chronic fatigue and immune dysfunction syndrome (CFIDS), the disorder typically presents with an acute onset of flu-like symptoms leading to fatigue and neuropsychological symptoms of at least six months' duration. The current syndrome bears a striking resemblance to the diagnosis of neurasthenia described a century ago. More that 20 symptoms are associated with CFS;[1] the most common symptoms and their frequency include:

- Fatigue (100%)
- Impaired cognition (50-85%)
- Depression (50-85%)
- Pharyngitis (50-75%)
- Anxiety (50-70%).

Despite more than 40 years of intense study into the etiology of CFS-type disorders, researchers have not come to any consistent findings or specific conclusions.[2] The symptoms associated with CFS overlap significantly with those of depression. This does not, however, negate the possibility of an underlying organic cause of CFS, particularly in view of the growing evidence
that depression itself has a physical cause. Possible etiologies include active acute viral infection, an immunological disorder, and a dysfunction of the reticular activating system in the brainstem or its cortical projections.[2]

The Centers for Disease Control and Prevention (CDC) has proposed criteria for a case definition of CFS.[3] Data has not confirmed their attempt to establish a uniform basis for this heterogeneous disease.[1]

Demographics and Physical Findings

Although sometimes called the "yuppie flu," and the majority of patients are between 30-40 years of age, CFS occurs throughout adulthood. Between 70% and 80% of patients are women, and the prevalence varies between 0.03% and 0.15% of the population, depending on the criteria used.[4]

The patient's medical history prior to onset of symptoms provides few clues except for a higher-than-average incidence of atopic and allergic disease. A routine physical often proves unremarkable. Typical nonspecific findings include pharyngeal inflammation, posterior cervical adenopathy, abnormal Romberg sign, impaired tandem gait, macular rash, fever, hepatomegaly, splenomegaly, and axillary lymphadenopathy.

Routine laboratory testing is recommended primarily to exclude other common causes of fatigue. In addition, the following tests can be helpful: Epstein-Barr serology, check x-ray, rheumatoid factor, anti-nuclear factor, serological testing for cytomegalovirus, Q fever, toxoplasmosis and HIV.[5]

Abnormally elevated laboratory values, however, do occur among CFS patients. These include:

- Immune complexes
- Immunoglobulin G
- Antinuclear antibody titer
- Alkaline phosphatase
- Cholesterol
- Lactate dehydrogenase
- Atypical lymphocyte count.

One study found a statistically significant correlation between elevated alkaline phosphatase and elevated IgG levels,[6] whereas another noted that CFS patients were folate deficient (less that 3 mg/L) without being anemic.[7] Although these tests may support a diagnosis of CFS, they lack sufficient sensitivity to be considered diagnostic tests.[8]

Researchers have undertaken assessments of growth factor levels as well as various indications of immune function, including interleukins, cytokines, antimuscle and anti-CNS circulating antibodies, serum markers of inflammation, and immune activators, but results have proven inconclusive. Neuroimaging studies using MRI and SPECT, however, do show abnormalities that
warrant further investigation. In addition, neuroendocrine abnormalities in the hypothalamic-pituitary-adrenal (HPA) axis and psychoneuroimmunological studies are other promising areas of research.

Differential Diagnosis

According to Dr. Anthony Komoroff,[1] three illnesses can be confused with CFS: systemic lupus erythematosus (SLE), mild forms of multiple sclerosis (MS), and depression. I would add to this list fibromyalgia, another perplexing syndrome. Given the fact that more and more evidence accumulates concerning structural brain abnormalities in depression, CFS may be considered a variant form of depression. Mild MS and SLE may be confusing initially, but the course of these latter illnesses may vary.

The boundary between health and illness may be difficult to delineate in chronic illness. There is no doubt that CFS leads to significant suffering, compounded by the patient's relentless pursuit of legitimizing the illness. According to Komoroff, we are not well-served by the prevailing biomedical model, with its reductionism and implicit mind-body dualism. In fact, holistic and alternative models may offer a better explanation to CFS.

A clinician treating CFS has to think "out of the box." I suggest a practical, evidence-based approach to assessment and initial management of the patient with CFS. First of all, it is extremely important to establish a rapport with the patient. The patient is often defensive and frustrated and deserves an open-minded and empathetic approach to the problem. Often the patient believes that the symptoms are a result of an organic disease process, whereas many physicians believe the converse--the disease is psychological in origin or psychiatric in nature. One effective way of establishing a therapeutic alliance is to inquire about the patient's belief concerning the disease and threat those beliefs with respect (even if the physician does not agree with them). Often patients have experienced so-called "illness disconfirmation" from others (including professionals), and allowing the patient to ventilate previous dissatisfaction is both informative for the physician and therapeutic for the patient.

The most important part of patient assessment is the history.[5] Since fatigue is usually the presenting problem, the patient's clear description of this symptom and its duration and effect on activity is important. The fatigue encountered with CFS is a profound lack of energy exacerbated by exertion, but the symptoms appears to be CNS-related and not caused by muscle abnormalities. Fatigue should be distinguished from sleepiness (suggestive of a major sleep disorder) or anhedonia (more indicative of a major depression). Inquiries into changes in daily activities pre- vs. post-illness can help assess the extent of disability the patient is experiencing.

Along with a detailed inquiry about fatigue, the physician should elicit a complete list of other symptoms from the patient. Somatic symptoms often associated with CFS include low-grade fever, nonexudative pharyngitis, palpable or tender lymph nodes, muscle weakness, myalgias, recurrent headaches, and migratory arthralgia. Sleep disturbances are common and may play a role in the development of symptoms, as experimental sleep deprivation can mimic the symptoms and endocrine profile of CFS.[5] Excessive time in bed can produce or exacerbate sleep problems as well as symptoms of CFS. Cognitive problems, such as poor concentration and memory, are often prominent: patients often describe experiencing slips of the tongue, grasping for the correct word, and impairment of short-term memory.
Physical symptoms, when present, should be investigated to rule out other illnesses. Some physical abnormalities, like muscle wasting and postural hypotension, may be the result of prolonged inactivity and bedrest.

Treatment

Although the patient may dwell on the causes of the disease, a discussion of what obstacles stand in the way of recovery is a more productive and pragmatic approach. The physician should assume a positive approach to the cause of symptoms and assessment of predisposing triggers and perpetuating factors. Since prolonged inactivity perpetuates the illness, the physician should encourage a gradual and consistent increase in activity with planned rest periods with appropriate, achievable targets. The patient should be aware that resuming activity will likely be accompanied by some discomfort but is not an indication of relapse or worsening of the disease. Assuming regular sleep patterns and limiting time in bed also help reduce daytime fatigue.

In some patients for whom depression is the predominant perpetuating factor, a trial of antidepressants may be the first priority. Others who believe that any activity will worsen the disease or have other unhelpful beliefs often benefit from discussion and education or more formal cognitive behavioral therapy.

A variety of novel pharmacologic agents have had anecdotal efficacy, including magnesium injections, immunoglobulin infusions, and fish oil supplements. Ineffective treatments include acyclovir and anti-candida therapies. Holistic approaches and alternative therapies, including acupuncture, are now under investigation as well. Patients should be made aware that the efficacy of such treatments is unknown.

Illnesses like chronic fatigue syndrome highlight the problems physicians experience when faced with medically unexplained illnesses. Despite our current lack of knowledge about its etiology, however, CFS is a potentially reversible disorder when physician and patient work together on a treatment plan.

References


