Chronic fatigue syndrome

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It is now 11 years since Holmes et al published the first significant article addressing the definition and diagnostic criteria for chronic fatigue syndrome (CFS). Since then numerous publications have appeared, including a significant update and simplification of the diagnostic criteria by Fukuda et al in 1994, which had input from Australian clinicians and researchers.

In 1994, in response to perceived clinical practice variations in relation to CFS, a Ministerial Review Committee was established to develop diagnosis and management recommendations for the medical profession in Australia. Outcomes of this initiative included funding for a comprehensive, evidence based set of clinical practice guidelines, compiled by a multidisciplinary working group and published in December 1997 and a survey of general practitioners' (GPs) opinions and practices in relation to CFS. The survey, compiled in 1995, is reported in this edition of *Australian Family Physician* and provides a valuable insight into GPs views and practices at that time.

The existence of CFS as a clinical entity that is not explained by illness models relevant either to a somatoform disorder, malingering, major depression or 'burn-out' has become less of an issue in recent years. The increasing understanding of biopsychosocial interactions and comorbidity in illness, have made us less dismissive of an illness associated with difficulties in sleep, pain perception, and mood. Symptoms of autonomic nervous system dysfunction such as drenching sweats, blurred vision and palpitations may complicate the clinical picture in this illness. Similarly, abnormal illness behaviour exacerbating fatigue may exist at times as a comorbidity in CFS. We no longer see these entities as negating the validity or existence of an associated underlying illness.

Consequences of extremes

As we begin to better understand the complex interaction between the psychosocial and biological components of illness we are becoming more prepared to work with each of these to provide the best outcome for the patient.

Further complicating the illness is the frequent development of symptoms after a prolonged period of physical and/or psychological stress. Most individuals who develop this disorder have pushed themselves to extremes of physical and mental endurance over a period of 12 months or more. Those affected range from students to professionals, farmers to elite athletes; they range from reluctant to willing participants in a full range of work, family and social pursuits. If CFS has become more prevalent in the late twentieth century, this may reflect the extremes to which we are willing to extend ourselves, by choice or otherwise. The resultant adverse effects may arise from the important interaction between psyche and soma. An interesting

biological parallel may exist here in relation to the concept of neuronal fatigue and the post polio syndrome.

A purely psychodynamic model does not accord with experience. For instance, recurrent unexplained symptoms in teenage or earlier childhood years as occur in the somatoform disorders, are not usual; nor is intentionality with clear secondary gain, as occurs in the malingerer. There will inevitably be overlap into these areas. However, prior to developing this illness many patients have lived uncomplicated, functional, productive and busy lives, with no hint of psychiatric or psychological disturbance or frequent recourse to medical consultations.

The pathogenesis of CFS remains poorly understood. An excellent overview of current evidence in relation to this appears in the draft clinical practice guidelines published by the *Medical Journal of Australia.* Research in the developing field of psychoneuroimmunology as well as the neuroendocrine system, has given rise to a number of possibilities. Any model needs to incorporate input from a range of psychological and physiological insults and establish a final common pathway that mediates symptoms. Current consensus is that this involves entities such as the brain stem reticular activating system and the hypothalamic-pituitary-adrenal axis. Important interactions are also known to occur between stress and immune function and a number of immunological abnormalities have been identified in this illness. However, more work needs to be done to reproduce these preliminary findings.

Active management

Management of patients with CFS requires empathy, patience and commitment. Barsky has highlighted the danger in validating a particular pattern of dysfunctional behaviour and of slowing recovery by providing an illness label. It is well to be aware of this. However, most of these patients are distressed and confused by their symptoms and they seek help from a wide range of health practitioners. We have a responsibility to respond from out scientific base, limited as it is at the present time. We must listen actively to their story, acknowledge what they are feeling, be sure we have excluded other medical or primary psychiatric illness and guide them clearly and firmly along a path that addresses psychological, social and biological components of the illness, providing hope and the expectation of improvement. We will emphasise our own fears of impotence in relation to this illness if we are abrupt, judgmental and unsympathetic in our approach to these patients.

Evidence at this time suggests that graduated exercise and cognitive behaviour therapy (CBT) are beneficial in facilitating improvement. Specific drug or other therapies may be indicated for sleep disturbance, anxiety depression and pain. Support may be required if appropriate financial assistance is to be obtained.

With optimal management, prognosis is favourable. While it is common for symptoms to persist for 2-4 years and sometimes longer, most patients gradually improve and return to living productive, satisfying lives. However, returning to excessive levels of physical or mental effort or stress, is prone to result in a recurrence of the symptoms. Addressing this is an

important part of the management.

The survey by Steven et al reported in this edition of *Australian Family Physician*, was undertaken in 1995, before much of our current understanding of this illness was clearly presented in the literature. In the light of this, the results are quite encouraging with a number of essential symptoms and an appropriate approach to investigation being identified by up to 75% of respondents. Omission of Epstein-Barr virus (EBV) serology from the investigations performed is appropriate but surprising as most patients have had this performed as part of their routine work-up. An erythrocyte sedimentation rate would be a valid screening test although this was not identified by the group. Information regarding management strategies suggests more needs to be done in this area in particular. In relation to this and to their expressed wish for clear diagnostic criteria, excellent information is now available from articles published in Australian, British and American scientific literature. Both patients and practitioners will benefit if these are followed.