Letters to the Editor

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Article on CFS Does Not Reflect Current Best Treatment Practices

Original Article: Chronic Fatigue Syndrome: Diagnosis and Treatment

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Available at: http://www.aafp.org/afp/2012/1015/p741.html

TO THE EDITOR: We feel that the overview of the diagnosis and treatment of chronic fatigue syndrome (CFS) was incomplete and did not reflect current best treatment practices. The discussion of current CFS research omitted key studies, such as evidence from prospective cohort studies indicating that up to 10 percent of patients with postinfectious syndromes develop CFS, regardless of the type of infectious agent.[1] Biomarker research has shown distinct patterns of gene expression correlating with cytokine, adrenergic, and sensory receptor changes after modest exercise in patients with CFS compared with healthy sedentary patients.[2] Indeed, many peer-reviewed publications support a physiologic etiology of CFS.

The authors emphasize behavioral treatments for CFS, but we have found these treatments to be effective only in helping patients cope with the illness. Graded exercise therapy (GET) should be administered with great caution by physicians familiar with CFS, because even mild exercise can provoke postexertional malaise and severe symptom flare-up that correlate with gene expression findings.[3] The authors also do not address diagnosis and management of orthostatic intolerance, a common and significant issue for patients with CFS.[4]

Health care professionals should avail themselves of expert resources to provide the best care to patients with CFS. The Centers for Disease Control and Prevention offers continuing medical education courses on CFS at http://www.cdc.gov/cfs/education/index.html. A free primer published by the International Association for Chronic Fatigue Syndrome/Myalgic Encephalomyelitis is available at http://www.iacfsme.org/Home/Primer/tabid/509/Default.aspx.

CFS is a physically debilitating illness that places great burdens on patients and their families. Primary care physicians who understand the physical complexities of the illness will be able to better assist these patients in managing this serious chronic illness.

LUCINDA BATEMAN, MD
JENNIFER SPOTILA, JD
Salt Lake City, Utah
E-mail: fcclinic@xmission.com

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Author disclosure: No relevant financial affiliations.

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IN REPLY: We appreciate this thoughtful letter. We do not dispute a physiologic etiology for CFS; our article mentions both postinfectious and genetic factors as possible contributors to the syndrome.

Because there is no known cure for CFS, the family physician should assist patients in coping with symptoms in the most effective way possible. We emphasized behavioral treatments, not to imply that the etiology of CFS is psychological, but because the weight of evidence favors them at this time.

The PACE trial was by far the largest and best-designed study of treatments for CFS. It was a randomized controlled trial demonstrating that cognitive behavior therapy

(CBT) and GET have moderate benefit in persons with CFS. Both were superior to specialist care alone and adaptive pacing therapy, defined as "helping the participant to plan and pace activity to reduce or avoid fatigue."[1] We did not cite the International Association for Chronic Fatigue Syndrome/Myalgic Encephalomyelitis primer because it was published after our literature search date. Although the primer contains useful information for family physicians treating CFS, it deemphasizes CBT and GET because although they "may improve coping strategies," they do not "cure the illness."[2]

Some have expressed concerns that the PACE trial interventions could be harmful[3]; however, there was no difference in adverse events between the CBT and GET groups and the pacing therapy and specialist care groups.

Because postexertional malaise is a hallmark of CFS, it is easy to conceive how therapies focused on increasing activity that are supervised by those who do not understand the illness could lead, and likely have led, to exacerbation of symptoms in some cases. I concur with Drs. Bateman and Spotila that family physicians should refer patients for these therapies only to specialists with expertise in CFS and the dangers of overexertion. In addition, the results of the PACE trial should not be generalized to patients with severe CFS (e.g., those who are bedbound). Applied safely and appropriately, however, CBT and GET may help patients with CFS cope with this disabling illness.

JOSEPH R. YANCEY, MD
Fort Belvoir, Va.
E-mail: joe.yancey@us.army.mil

Author disclosure: No relevant financial affiliations.

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Corrections

Error in table note defining a positive screen. The article "Screening for Depression" (January 15, 2012, p. 139) contained an error in the note in the legend of Table 5 (p. 142). The note incorrectly indicated that a "yes" response to at least two questions is considered positive for depression. The note should have read as follows: "A 'no' response to question 1, or a 'yes' response to questions 2 through 5 each counts as one point. A score of two or more points is considered a positive screen." The table has been corrected online and is reprinted here.

Table 5. Five-Item Geriatric Depression Scale

1. Are you basically satisfied with your life?	Yes/No
2. Do you often get bored?	Yes/No
3. Do you often feel helpless?	Yes/No
4. Do you prefer to stay at home rather than going out and doing new things?	Yes/No
5. Do you feel pretty worthless the way you are now?	Yes/No

NOTE: *A "no" response to question 1, or a "yes" response to questions 2 through 5 each counts as one point. A score of two or more points is considered a positive screen.*

Information from reference 26.

Corrected footnote in immunization schedules. The Practice Guidelines "ACIP Releases 2013 Immunization Schedules" (February 1, 2013, p. 204) contained an error in footnote 13 of the recommended immunization schedule for persons aged 0 through 18 years and the catch-up immunization schedule for persons aged 4 months through 18 years who start late or who are more than 1 month behind. The third bullet point under "Routine vaccination" should read "For children aged 2 months through 10 years with high-risk conditions, see below" rather than "For children aged 9 months through 10 years with high-risk conditions, see below." The online version of the immunization schedules has been corrected. ■