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MANAGEMENT

In addition to an extensive history and physical, the best management plan provides individualized supportive and symptomatic treatment. Also of therapeutic value is educating patients about CFS and validating their illness experience.

Symptomatic Treatment | Treatment is directed toward the most problematic symptoms, as prioritized by the patient, but only after underlying conditions applicable to those symptoms have been investigated and excluded. Such conditions may include sleep disturbance, pain, weakness, light-headedness, memory or concentration problems, depression or anxiety. CFS patients are frequently sensitive to medications, particularly sedating medications. Therefore, therapy is initiated with a fraction of recommended dosages and increased slowly as needed to tolerance and individual therapeutic levels.

Diet | Encourage a well-balanced diet. Ask the patient about use of alternative food or drug supplements and OTC products to determine safety, efficacy and possible negative interactions with prescribed medications and therapies.

Activity | The majority of people with CFS are affected by postexertional malaise, which is defined as exacerbation of symptoms following physical or mental exertion, with symptoms typically worsening 12-48 hours after activity and lasting for days or even weeks. Postexertional malaise and exercise intolerance, though not unique to CFS, may help distinguish CFS from other disorders.

Some people with CFS inappropriately avoid all activity because personal experience has demonstrated a link between exertion and symptom expression and severity. An even greater number of people engage in an endless "push-crash" cycle of activity. It is important that emphasis be placed on balancing activity (preventing over- and under-activity) and stopping activity before illness and fatigue are exacerbated. Appropriate rest is a key element of the CFS management plan.

Partnering with the patient to develop a highly individualized activity plan is key to success. The health care practitioner can assist in identifying goals and setting realistic expectations. The primary objectives for the plan are to improve function and quality of life. Gear activities toward improving function in areas that are of greatest importance in achieving activities of daily living.

It is imperative that any CFS activity plan be started slowly and increased slowly. When beginning an activity program, some patients may only be able to exercise for as little as one minute. Avoid traditional aerobic-type exercise programs. Simple stretching and strengthening exercise using only body weight for resistance is a good starting place for most people with CFS. However, people who are severely affected will need to start very slowly; hand stretches and picking up and grasping objects may be all that can be managed. All exercises need to be followed by a rest period at a 1:3 ratio—exercising for one minute and then resting for three minutes.

Counseling | A supportive counselor can help people cope with the anxiety, depression, grief, anger and guilt that often accompany any chronic illness. While it is not a cure for CFS, cognitive behavioral therapy has helped some patients develop realistic goals and effective coping mechanisms that contribute to better functioning.

Ongoing Care | Perhaps the most crucial role of the health care practitioner is to provide support and active follow-up, not only for the patient, but for family and significant others as well. Providers need to evaluate new symptoms for possible development of other illnesses and monitor any deterioration in function, tailoring the management plan accordingly.

Disability | By definition, all people with CFS are impaired. Impairment doesn't necessarily equal disability, and many patients are able to adapt to their current impediments by consulting with employers or rehabilitation specialists. Other individuals suffer occupational disability. The process of applying for disability benefits is protracted and frustrating. Applying for disability benefits is often emotionally difficult as patients attempt to accept the fact that they are no longer able to work and must rely on disability benefits for financial support.

The health care professional is a major source of documentation in the disability process. Keeping good clinical notes and using simple assessment tools to track health status are important to the process. For additional information on CFS disability issues, visit www.cdc.gov/cfs.

ADDITIONAL RESOURCES

A CFS toolkit for health care professionals, in-depth information on CFS patient care, complimentary self-study continuing education courses and research findings are available at www.cdc.gov/cfs.

RECOGNITION AND MANAGEMENT OF CHRONIC FATIGUE SYNDROME

A RESOURCE GUIDE FOR HEALTH CARE PROFESSIONALS

Visit www.cdc.gov/cfs
for more in-depth information on patient care, research findings and continuing education opportunities.

WHAT IS CFS?

Chronic fatigue syndrome (CFS) is an illness characterized by prolonged, debilitating fatigue and a characteristic group of accompanying symptoms, particularly problems with memory and concentration, unrefreshing sleep, muscle and joint pain, headache and recurrent sore throat. It is marked by a dramatic difference in pre- and post-illness activity level and stamina.

CFS shares various symptoms with many illnesses, including fibromyalgia, lupus, Lyme disease, sleep apnea, narcolepsy, untreated hypothyroidism, chronic hepatitis and depression.

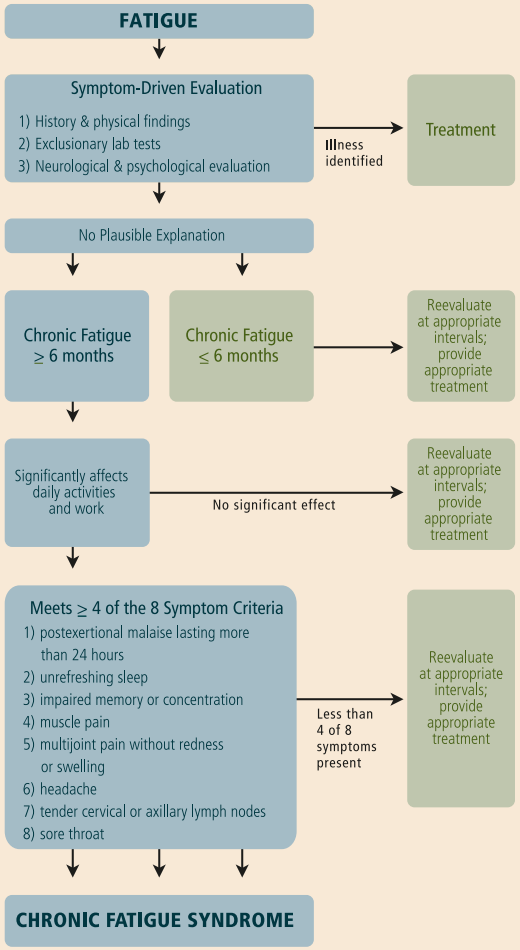
Prevalence and Risk Factors | More than one million people in the United States are afflicted with CFS. Millions more have debilitating fatiguing illnesses that present with fewer or less severe symptoms than those indicative of CFS. Although CFS is most common in 40- to 60-year-old women, it is important to note that CFS affects both sexes and all race, age and socioeconomic groups. The majority of patients seen by health care professionals in private offices or clinics are Caucasian; however, studies suggest the highest rates may be in Latinos and African Americans. Similar illnesses have been seen in adolescents and children, but prevalence data are limited for these populations.

Prognosis | There is little known about long-term outcomes of CFS. It appears that many people with an acute onset, i.e., CFS following an infection, improve within two years, although they may continue to experience symptoms at a less debilitating level. Individuals with a gradual onset may experience a prolonged course of illness, characterized by periods of remission and exacerbation. Symptom improvement, however, may occur even in people who have been ill for years.

Diagnosis | Despite two decades of research, CFS remains a clinical diagnosis without specific laboratory tests or markers. The process of sorting through symptoms and assessing abnormalities using a thorough history and physical exam is similar to the clinical assessment of any illness. The major difference is the more extensive exploration of the patient's subjective experience, i.e., patient symptom complaints and functional limitations. CFS is a diagnosis of exclusion.

CFS should be considered in a patient who presents with six months or more of unexplained fatigue and other symptoms, without an alternative medical or psychiatric explanation. Although the diagnosis of CFS requires fatigue of at least six months' duration, fatigue alone is not diagnostic. Rather, the entire symptom complex must be considered.

CFS EVALUATION AND DIAGNOSIS MODEL



The International Case Definition for evaluation and diagnosis of CFS, in the model shown above, guides the clinical diagnosis. If fewer than four of the eight symptom criteria listed in the chart are present, the clinician should exercise judgment based on the course of illness, other symptoms and the patient's medical history. The following questionnaires assist with the identification and monitoring of patients with CFS: SF-36, Multidimensional Fatigue Inventory (MFI) and the CDC Symptom Inventory. For additional information on these instruments and other assessment tools, visit www.cdc.gov/cfs.

HISTORY AND PHYSICAL EXAM

The history and physical examination provide important clues to the appropriateness of a CFS diagnosis. The examination must include a routine neurological and psychological screening, a thorough physical exam and routine laboratory tests:

- Urinalysis
- Complete Blood Count (CBC) with leukocyte differential
- Erythrocyte sedimentation rate (ESR)
- Total protein
- C-reactive protein
- Alanine aminotransferase (ALT) or aspartate transaminase serum level (AST)
- Alkaline phosphatase (ALP)
- Blood urea nitrogen (BUN)
- Electrolytes
- Creatinine
- Albumin
- Globulin
- Glucose
- Calcium
- Phosphorus
- Thyroid function tests (TSH and Free T4)
- ANA and rheumatoid factor

Further tests may be indicated to confirm or exclude a diagnosis that better explains the fatigue state (i.e., polysomnography for suspected sleep apnea) or which are suggested by results of the above screening tests.

Symptom Assessment | Evaluation of patients with unexplained chronic fatigue must include the frequency, severity and duration of accompanying symptoms. The Numeric Rating Scale can simplify assessment and documentation of the person's subjective experience. For symptom intensity, patients are asked, "On a 0 to 10 scale, 0 being no (SYMPTOM) and 10 being the worst (SYMPTOM) you can imagine, what number would you say your (SYMPTOM) has been over the last week?"

For symptom impact, patients are asked, "During the past week, how much have your symptoms interfered with your usual work, school, home or social activities, with 0 being does not interfere at all and 10 being completely interferes?"