CRITICAL CONSIDERATIONS

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If democracy and not dictatorship prevails in the UK, then mindful of the recent submission of Professor David Healy from Cardiff University to the House of Commons Health Select Committee that "Every patient who enters a clinical trial in the United Kingdom is putting every Member of Parliament in a state of legal jeopardy" (http://www.meactionuk.org.uk/HoC_Select_Ctte_Inquiry_into_Pharma.htm), the UK ME community may wish to require as a matter of urgency that their Member of Parliament contacts in writing both the Chief Executive of the Medical Research Council (Professor Colin Blakemore) and the Chief Medical Officer (Professor Sir Liam Donaldson) -- with copies to both the Medical Defence Union and The Medical Protection Society -- requesting written assurance that their constituents with myalgic encephalomyelitis (ME) who are to take part in the MRC PACE trials on "CFS/ME and fibromyalgia (FM)", or who are to be referred to any of the newly funded centres for "CFS/ME/FM" will not, as a direct consequence of the psychiatric intervention involved, suffer a foreseeable deterioration in their medical condition in the light of the published evidence that such deterioration would seem to be inevitable.

For psychiatrists of the "Wessely School" and for state officials whom they advise simply to say that they do not accept such evidence is indefensible and is not justifiable in law (see "Clinical Review: How does evidence based guidance influence determination of medical negligence?" Brian Hurwitz. BMJ 2004:329:1024-1028).

Professor Hurwitz states "discretion requires to be exercised in accordance with the patient's best interests. Evidence-based guidelines set normative standards but they do not constitute a de facto legal standard of care. The bottom line is: guidelines do not actually set legal standards for clinical care".

MPs might therefore be urged to request a credible explanation as to why both the MRC trials and the new centres will be employing cognitive behavioural therapy (CBT) and graded exercise therapy (GET) when there is significant publicly available evidence that such regimes may be actively harmful to those with ME / CFS because they are based on the psychiatrists' discredited assertion that "CFS/ME" is a "faulty belief system" that can be "corrected" by CBT and incremental aerobic exercise regimes.

Substantial mainstream published evidence that the psychiatrists are wrong was brought to the attention of both Professor Sir Liam Donaldson and Professor Colin Blakemore themselves, as well as to key members of the CMO's Working Group on "CFS/ME" and to members of the MRC Research Advisory Group on "CFS/ME" but it has been comprehensively ignored. It will in due course also be put before the National Institute for Clinical Excellence (NICE) when that body begins accepting submissions (probably in February 2005).

The issue is whether or not compulsory exercise regimes and "rehabilitative programmes" may be harmful to those with ME / CFS.

In 1999 Professor Paul Cheney from the US went on record as stating: "**The most important thing about exercise is not to have (patients with ME / CFS) do aerobic exercise. I believe that even progressive aerobic exercise is counter-productive. If you have a defect in mitochondrial function and you push the mitochondria by exercise, you kill the DNA**" (Lecture given in Orlando, Florida at the International Congress of Bioenergetic Medicine, 5th-7th February 1999).

Significantly, there is now further supportive evidence that has emerged from the 7th AACFS International Conference held in Madison, Wisconsin, from 8-10th October 2004: "**An analysis of metabolic features using MRSI (magnetic resonance spectroscopy imaging) showed elevated lactate levels, which suggests mitochondrial metabolic dysfunction similar to mitochondrial encephalomyopathy**".

Given this evidence, how can forced aerobic exercise be beneficial to such patients? Will the MRC trial participants be screened for such abnormalities before taking part in the aerobic exercise regimes that are the basis of the trial?

Since as long ago as 1996 it has been known that those with ME / CFS have abnormal lung function tests, with a significant reduction in all lung function parameters tested (see "Lung function test findings in patients with chronic fatigue syndrome" De Lorenzo et al. Australia and New Zealand Journal of Medicine 1996:26:4:563-564), and Jo Nijs from Belgium presented evidence at the Wisconsin international conference of underlying lung damage in ME / CFS through intracellular immune dysregulation with impairment of cardiopulmonary function.

How can forced aerobic exercise regimes be guaranteed to be harmless where there is existing underlying lung damage? What prior screening measures will be undertaken by the psychiatrists to determine whether or not trial participants have existing lung damage, or will their lack of fitness simply be ascribed to "de-conditioning"?

Further evidence of impaired oxygen up-take in those with ME / CFS was presented at the Wisconsin conference: a Spanish study on aerobic exercise by Anna Garcia-Quintana provided evidence that in ME / CFS, the average maximal oxygen uptake was only 15.2, whilst for sedentary healthy controls it was 25.9, but for physically active controls it was 66.6.

This accords with evidence from 1999 that showed impaired oxygen delivery to muscle in ME / CFS patients: oxygen delivery represents the ability to get oxygen into the small vessels of the muscle and the study demonstrated that ME / CFS patients had recovery rates for oxygen saturation that were 60% lower than normal subjects, leading to reduced exercise capacity (see "Impaired oxygen delivery to muscle in chronic fatigue syndrome" Kevin K McCully and Benjamin H Natelson. Clinical Science 1999:97:603-608).

How would forced aerobic graded exercise be beneficial to patients with reduced exercise capacity?

There is also evidence that many people with ME / CFS may have a serious heart problem. In April 2003, Arnold Peckerman MD from New Jersey reported findings to the annual meeting of the American Physiological Society that demonstrated via a sophisticated test that after exercise, the heart of those with ME / CFS pumped less blood than it did at rest. Normally the heart pumps out more blood on exercise, but this does not happen when ME / CFS patients are exercised. Peckerman is on record as saying: "Basically we are talking about heart failure. Chronic fatigue syndrome is a progressive disease".

Cardiologist Joseph Miller MD from Emory University agrees that these patients have serious heart problems: "A drop in (blood pumped by the heart) during exercise is actually a marker of significant coronary artery obstruction".

What are the risks of forcing such patients to undertake aerobic exercise regimes and "push themselves back to fitness"?

The ME community will recall the case of Brynmor John MP who had ME but who was advised to exercise back to fitness; he dutifully tried to do so but collapsed and died coming out of the House of Commons gym.

Of concern is the knowledge that patients to be enrolled in these trials will apparently be required to sign a statement giving their written consent and waiving their right to sue for damages should any harm flow from participation in the MRC exercise trials.

Finally, the issue of case definition for trial participants remains controversial because at the Edinburgh Science Fest held on 9th April 2004, it is understood that psychiatrist Michael Sharpe informed attendees that the MRC PACE trials would include those with fibromyalgia as well as "CFS/ME" as it was desirable to have as wide a catchment as possible, and it is also understood that GPs are to be offered "incentives" to refer as many people as possible with fibromyalgia to the new centres. However, this seems to have been re-thought, because in the current issue of the ME Association newsletter (issue 92, October 2004), Michael Sharpe and his co-organisers now state: "patients who only have fibromyalgia will not come into the trial. We will, however, note those who have both CFS/ME and fibromyalgia to see if having both affects response to treatments *(sic)*".

Given that fibromyalgia is a distinct diagnosis (ICD-10 M 79), the issue of obfuscation is real, not least because evidence from Wisconsin presented by Professor Robert Suhadolnick demonstrates that "the higher the RNase L activity, the lower the patient's ability to function. These patients also have a low molecular weight 37 kDa RNase L which is not found in healthy controls, patients with depression **or fibromyalgia patients**".

Members of Parliament need to be fully aware of these facts in order to protect the best interests of their constituents.