

Staged Management for Chronic Fatigue Syndrome

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Abstract

The "Chronic Fatigue Syndrome" is a multifactorial collection of illnesses which are very hard to distinguish from each other, but with fatigue, myalgia, cognitive impairments, and often digestive disturbances in common. The diagnosis is by exclusion of other conditions. This leaves the management. There is, as yet, no single cure. But a staged approach frequently leads to major improvement, if not cure.

Introduction

I have no idea what "Chronic Fatigue Syndrome"(CFS), or whatever label may be used, such as Neuromyasthenia, or Myalgic Encephalomyelitis, etc., is. However, the attempts of some Psychiatrists to claim it for their own notwithstanding, the evidence for its organicity is overwhelming.^{1,10} That being the case, it is entirely within the province of most General Practitioners, or Family Doctors, to manage.

The best explanation for it that I have been able to distill is that it starts with a stressed organism, usually a person with Type A personality, a workaholic, someone unable to refuse to take on new responsibilities, in other words a citizen — the kind of individual that no civilization can do without. On top of this comes stress from the various pollutants to which we are exposed, in the air, in water, in the food we eat, through other chemicals to which we become exposed. A virus infection, however one acquires it, is the final straw. No specific virus can be implicated, although the Epstein-Barr virus seems commonest in western North America.¹¹ In Europe it seems to be one of the enteroviruses.^{12,13} The viruses enter into a non-destructive relationship with either muscle cells,¹⁴⁻¹⁶ or in the brain,¹⁷ or both. In its attempts to attack the viruses, the body produces large amounts of the

cytokines, e.g. interferon and interleukin 2. It is the side effects of these agents which are responsible for most of the symptoms of the sufferers with CFS.¹⁸

One issue is quite clear, and that is that there is no single cure.

But before treatment can be undertaken, the diagnosis must be made. It is a diagnosis by exclusion. That is, the full clinical acumen of the practitioner must be brought to bear on the problem to make sure that no simpler, more easily treatable, condition(s) is present.

The differential diagnostic list includes depression, bipolar affective disorder, somatization disorders, the schizophrenias, multiple sclerosis, subacute combined degeneration of the cord (folic acid and vitamin B₁₂ deficiencies), amyotrophic lateral sclerosis, neurosyphilis, Parkinsonism, malingering (rare), chronic obstructive pulmonary disease, myocardial ischaemia, cardiomyopathy, cardiac valvular disease, peptic ulcer disease, chronic hepatitis, chronic pancreatitis, ulcerative colitis, Crohn's disease, irritable bowel syndrome, Giardiasis, gall bladder disease, chronic large bowel Candidiasis, hypothyroidism, hyperthyroidism, Addison's disease, diabetes, reactive hyperinsulinism, acute and chronic urinary tract infections, myopathies, fibromyalgia (with which it is often confused), food allergies or sensitivities, the anaemias, the arthritides, disorders of calcium, magnesium, zinc and copper, toxicity by iron, lead and mercury, and cancers of any body system. This list is not exhaustive. Often, though one tries to exclude these, the tests are not diagnostic and one has to wait for further diagnostic clues.

There are, in fact, in the history two very common diagnostic clues. If the patient has suddenly become intolerant of all but small amounts of alcohol, then CFS is almost certainly the diagnosis. Similarly, if the patient is intolerant of regular doses of the tricyclic antidepressants, CFS is almost certainly the

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diagnosis. If both, then there is little doubt at all. And these almost entirely eliminate most psychiatric diagnoses.

Probably the best policy of all is to maintain watchfulness over the patient's whole health with regular complete physical examinations and further diagnostic testing. In women breast self-examination and regular cervical smears, as recommended by the cancer agencies, is mandatory. In men, over the age of 45, annual prostate examinations are as mandatory.

Management Policies

A. *Candida*

Through bitter experience I have learned that the very first measure that I have to take, after a thorough history and physical examination, is to consider the issue of chronic bowel Candidiasis. Diagnostic clues to this tend to be that the patient is female, is fertile, has taken oral contraceptives, has been subject to vaginal "yeast" infections, and has been exposed to many courses of antibiotics. Men can experience Candidiasis too, especially if exposed to antibiotics, or are partners of women prone to Candidiasis. The only diagnostic test for this situation is colonoscopy with multiple biopsies, is expensive and is of high risk of serious complications. Stool cultures are useless.

By far the easiest way of making a diagnosis is to give a course of oral Nystatin, usually a dose of 1.5 million units three times per day for one week. This agent is not absorbed from the intestine and therefore cannot reach other places where chronic Candidal infection can occur. But it also means that no side effects are possible. If side effects do occur, they are due to the binding, colouring and preservative agents. Powdered Nystatin is available to get around this.

If chronic bowel Candidiasis is not involved, there is no response within the week. This does not mean that *Candida* cannot become involved later.

If there is a mild to moderate infestation by *Candida*, improvement starts to become apparent within two to three days. By the end of the week the patient is markedly better, but not well. A further month's course of Nystatin may restore the patient to

full health. Avoidance of sugary/starchy foods with recolonization of the bowel by *Lactobacillus acidophilus* usually prevents recurrences. If full health is not achieved within the month, then the *Candida* is only a contributory factor to the CFS and other measure must be taken. Even if full health is restored, recurrences can still occur, often from recolonization with *Candida* from either a consort, or from spores from sites not reached by Nystatin, such as the sinuses, middle ears, esophagus, bladder, prostate and vagina. Other agents which do penetrate to these sites can be helpful such as ketoconazole and fluconazole.

Where there is a severe infestation by *Candida*, in two to three days there is a marked deterioration in the patient's condition. In one case it was so severe that she was admitted to an intensive care unit. This situation is analogous to the Jarisch-Herxheimer Reaction which happens when syphilis is first treated. It is due to the breakdown of large numbers of Candidal organisms, and some of the breakdown products are absorbed causing the deterioration. In two to three days more, when most of the *Candida* is dead, there is a rapid improvement. A further month's treatment, with the recurrence preventive measures as outlined above, can cure the patient. This is the situation which carries the best prognosis.

B. *The Investigation*

If *Candida* is eliminated as a major player in the patient's condition, I proceed to the following investigations, which I have chosen as being most cost effective for my situation as a practitioner in rural western Canada: —

Haemocult x 3 — for visually inapparent bleeding from the bowel

Urinalysis

CBC, diff, ESR, RBC morph. — this group of tests alone can provide evidence of an active viral infection

6HOGTT — a six hour oral glucose tolerance test with a loading dose of 100 grams of glucose to detect Reactive Hyperinsulinism¹⁹ — often a complicating factor of varying severity

BUN & Creatinine — as measures of kidney function

Electrolytes, specifically Sodium, Potas-

sium, and Chloride

Plasma proteins, Serum bilirubin, and the liver enzymes, specifically ALP, γ GT, ALT, AST, CK, LDH — all as measures of liver function since chronic hepatitis resembles CFS very closely

Serum Calcium, Phosphate, Magnesium, and Zinc — symptoms of disorders of these can include fatigue and other brain dysfunctions

Lipid profile, specifically Triglycerides, Cholesterol, HDL, ChoLHDL ratio, serum appearance — isolated measurement of cholesterol alone being quite useless — since the patient is being studied holistically, a shame to ignore these

TSH — the single best measure of thyroid effect upon a patient — all other measures being merely of the levels of the various thyroid factors in the blood and not of how they actually affect the patient

Serum Estradiol, FSH, LH, Prolactin — the best tests of female sex hormone function — even giving a measure of disturbance of hypothalamopituitary function

Serum Testosterone and DHEAS — in men

Serum Folic acid and Vitamin B₁₂ — useless to test one without the other

Serum Iron studies and Ferritin — to screen for Haemochromatosis

Serum Copper, and Ceruloplasmin — to screen for Wilson's disease

Immunoglobulins, including IgE — IgM is often elevated in CFS, and IgE can (not necessarily does) indicate an allergic involvement in the patient's illness

Plasma proteins for Electrophoresis — the various forms of lymphoma can be detected with this, and can mimic CFS, there also being evidence of a higher than normal incidence of lymphoma in CFS patients

Antibodies for Hepatitis A, B, & C (especially if there is any abnormality of the liver function tests), Epstein Barr virus (not diagnostic for CFS, but strongly indicative), enteroviruses, Human Herpesvirus #6 [The B.C. Provincial Laboratory refuses to do this test, even though there is increasing evidence that this virus might be involved in CFS.]

HIV — only where the history suggests a risk for this, but this may become mandatory soon

RA Latex — for an underlying Rheumatoid process

ANA — for lupus

Many tests used by other doctors are not available to me, including tests of function of T-cell subtypes, Nuclear Magnetic Resonance Imaging (except in exceptional circumstances), Quantitative Electroencephalograms, Positron Emission Tomography, etc.

C. Treatment

I. Basic CFS Protocol

The above conditions being eliminated, I then place the patient on a three to four month trial of the following basic protocol:

1. Limit activity to 75% of what you think you can do. [This is the single most important measure without which nothing else can work. Some authorities go so far as to advocate limiting activities to 50% of the patient's tolerance. I emphasize that if the patient becomes tired with any activity at all, he/she has done far too much. It seems that CFS patients must reserve at least 25% of their energy for getting better.]
2. Reduce stress to a minimum — a real motherhood piece of advice, which is often impossible to achieve.
3. Vitamin C as per HOW TO TAKE THE RIGHT AMOUNT OF VITAMIN C FOR YOU
4. Calcium/Magnesium to equivalent of 1 000mg Calcium per day for muscle pains & cramps.
5. Evening Primrose oil (EFAMOL) 8 capsules per day.²¹
6. Avoid junk foods.

FORMS OF VITAMIN C

- a) Vitamin C 1000mg tablets (best to take the strongest because they are the cheapest) — if there are side effects from these, they are not due to the vitamin but the additives in the pills, corn starch being the most likely. In this case try brands without corn starch, or use the pure crystalline powder, as below.
- b) Vitamin C powder - Ascorbic acid (with a quarter teaspoonful of baking soda to neutralise it — if the pills cause acidity

too, use baking soda with them as well), or Calcium ascorbate, or Sodium ascorbate —> teaspoonful roughly = 1000mg. Use dissolved in unsweetened juice or water - does not taste good, like every excellent medicine.

HOW TO TAKE VITAMIN C

- a) Take it after food either three or four times per day, depending on your convenience and choice.
- b) Start about 1000mg per dose.
- c) Every day increase the dose by 1000mg per dose: Day 1 - 1000mg three or four times per day; Day 2 - 2000mg three or four times per day; Day 3 - 3000mg three or four times per day, and so on
- d) Continue, no matter how large the dose, until you get diarrhea
- e) Cut the dose down to the largest dose at which you do not get diarrhea. The absolutely perfect result is to have two large bowel motions per day, no thicker than your little finger, and of the consistency of soft toothpaste so that it is easy and comfortable and satisfying.²⁰

Most patients will show some improvement on this line of management. In fact, if the duration of the illness has been less than two years, my experience is that a substantial majority of these patients will be cured by this line of management.

Even if a cure does not occur this does bring the patient on to a new plateau, and every other measure taken from this point on may bring the patient to a new plateau.

II. Other Therapies

Guided by the result of the investigations, and other clues, I find that the following measures can improve matters for patients, bringing them stepwise to new plateaus:

a) Hypoglycaemia type diet. Particularly if the patient has an abnormal glucose tolerance test showing Reactive Hyperinsulinism, this is a slightly more rigorous form of the "junk free diet" emphasizing a good breakfast and small, frequent snacks through the rest of the day, as opposed to three square "gorges".²²

b) Therapeutic Fast + Provocative Food Testing. Especially if there is reason to believe that sensitivities to certain foods

may be present,²³ a therapeutic fast may be suggested as a preliminary to provocative food testing.²⁴ See Appendix.

c) Sleep. Lack of effective sleep is among the most distressing of the symptoms of CFS. The usual hypnotics are usually ineffective or poorly tolerated. As noted above, most of the tricyclic antidepressants are poorly tolerated, almost diagnostic of CFS. But small doses of such antidepressants may help sleep quite well. The best tolerated drug of this group seems to be Trazodone. Zopiclone, not an antidepressant, also seems well tolerated and effective for sleep. Clonazepam, alone of the Benzodiazepins, also seems helpful.

d) Antidepressants. While CFS is not depression, depression often logically occurs in CFS and makes it the potentially lethal condition that it is through the risk of suicide.

The Serotonin Re-uptake Inhibitors, in small doses, such as Doxepin, Clomipramine and Trazodone are often effective and tolerated.

Some of the Selective Serotonin Re-uptake Inhibitors are even more effective, but they take between one and four months to begin to show their effectiveness. Often gastrointestinal disturbances occur early on with them, but usually these settle down again quite soon. Fluoxetine (Prozac) I have not found useful. But many patients have benefited from Sertraline. I have no experience with Fluvoxamine, but my impression is that it might be useful. Since these agents work best if given in the morning after breakfast, they may be used in combination with the drugs used to help sleep. Phenelzine, a monoamine oxidase inhibitor, has helped one of my patients.

e) Thyroid hormone. Even if thyroid function testing seems normal, if the patient's basal temperature is below 36°C, a trial of thyroid hormone might improve the energy levels of the patient. But this should be monitored with frequent TSH tests to prevent hyperthyroidism, which can be very exhausting and dangerous.

f) Vitamin B₁₂. Even if the blood vitamin B₁₂ levels are normal, empiric injections of vitamin B₁₂ have helped a lot of my patients. I am not at all impressed with oral therapy with this vitamin. Equally I used to be

prejudiced against cyanocobalamin, but I no longer feel that hydroxycobalamin is worth the trouble. The dose and frequency of injections are highly individual. The colour of the injection solution is the natural colour of the vitamin, not that of any additive, since it is self-preserving. The best dose is that which just tinges the urine some time over the next six hours or so after an injection, ranging from 1000ug to 25,000ug per dose. And the benefits of each injection, if an effective dose is given, are apparent within one to two days. How long each injection is effective is also highly variable. Some patients need an injection every day, every second day, or so, up to every one to two months.

If the dose of the vitamin B₁₂ has to be reduced or given less frequently, as shown by increased spillage of colour into the urine, this is an indication that the patient's condition is improving. A similar effect happens with vitamin C, a return of diarrhea forcing reduction of dosage indicating an improvement of the illness.

g) Dihydroepiandrostenol (DHEA). This agent is an intermediary between cholesterol and the sex hormones. Only one of my patients has had benefit from it. Another, a woman, experienced virilization with it. I cannot recommend its use in women.

h) Ubiquinone (Co-enzyme Q10). This substance is also derived from cholesterol and is critical in the cellular energy generating system called oxidative phosphorylation. Hard to get, it is nonetheless often helpful in improving patients' energy levels to a greater or lesser extent — rather like vitamin B₁₂. 150 to 300mg per day seems the best doses range.

i) Niacin. The famous Niacin flush is very exhausting to patients with CFS. This limits its usefulness. But if it can be tolerated in the dose of 3,000mg per day, it does seem to help with both the depression and the poor energy. The procedure I use to introduce it is as follows:

Start with 100mg tablets. Take 1/2 three times per day after meals for one week. Then take 1 three times per day after meals until finished. Then switch to the 500mg tablets. Take 1/2 three times per day after meals for one week. Then take 1 three times per day after meals for one week. Then take 2 three

times per day after meals for the rest of your life.

j) Pyridoxine. Vitamin B₆ does help in CFS in a dose of 500mg per day. The reported neuropathy, which has scared many patients from taking it, only happens if no other vitamins are being used and is very rare. It is particularly useful in women if the CFS is complicated by Premenstrual Syndrome when the dose is doubled from the time of ovulation to the onset of menses. The effect is partially, at least, due to the inhibition of Prolactin from the Pituitary.

k) Thiamine. Vitamin B₁ helps in a fashion similar to Pyridoxine, but I know of no corresponding endocrine effect.

l) Other vitamins. On an individual basis combinations of other vitamins, water soluble and fat soluble, have also helped some patients. I know of no way of predicting who will respond to what, except by trial and error.

m) H₂ blockers. These agents are most commonly used in the treatment of peptic ulcer disease. But they are known to modulate the immune response. There are some reports of benefit in CFS patients. I have to say that I have not found any effect. But that only may mean that I have not tried them in patients who would respond.

n) Activation. Progressively increasing exercise is advocated by some. All I can say is that the benefits they report can only mean that they were not treating CFS patients, since such a programme is typically devastating to patients that I have seen who have tried it. This is not to say that increasing activity is not a good thing, but it must be restricted to the limits of the patients' energy levels. Otherwise they get worse not better.

o) Analgesia. Non-steroidal anti-inflammatory drugs are almost universally unhelpful in patients with CFS. The one exception seems to be Ketorolac which is helpful with the muscle pains. As the muscle pains improve with the general improvement in the patient's condition, the pains tend to become localised into discrete trigger points. These respond, just as in Fibromyalgia, to local injections of local anaesthetics within seconds. Such injections are not curative however, but the need for them, that is the number of trigger points, becomes less with

time.

p) Psychotherapy. The only psychotherapy of any value to CFS patients is explanation of the condition and education about its nature and management. There have been numerous attempts by psychiatrists to rationalize this condition as being in some ways psychogenic²⁵²⁷ and to make it their exclusive arena of management. But their arguments have been subject to close critical study and found lacking in any factual basis.^{28,29} Other measures which do help include relaxation techniques such as deep, slow breathing, balanced relaxation (especially helpful with headaches), focussed relaxation (especially helpful when there are stress effects from the unconscious, more effective than formal psychotherapy, and cheaper), relaxation tapes (but can be a stress to a CFS patient in their own right), and meditation.

None of these measures are curative, but, when they, or any combination, are added to the basic protocol, the combination may bring the patient as close to a cure as can be expected. And I must emphasize that when a treatment has been tried, and has shown no benefit over three to four months, it ought to be abandoned.

I also have to grant that a substantial portion of patients become well again in time. These treatments, it might be argued, may be of purely placebo effect. But no one has shown that CFS is a placebo responsive illness. Nor do placebos take months or years to take effect.

Conclusion

No curative therapy for CFS is yet available, except, in some instances, when treatment can be begun in less than two years from the onset of the illness. But in a staged manner considerable improvement can be achieved in a majority of patients.

Appendix

The following is the handout I provide to the patients to read and consider at length before they embark upon a Therapeutic Fast:

How and Why to Fast

Introduction

Fasting and starving are two different things.

Starving happens when a person gets just a small amount of food. The person feels worse and worse, and becomes increasingly ill. Ultimately, death occurs.

When a person Fasts, he/she starts feeling as if he/she is starving. This goes on for 48 hours, the person feeling worse and worse -and often wondering what they are doing and why. Then a chemical shift occurs in the body. It begins around the 48 hour mark. As it develops, the person feels better and better, and his/her mind becomes clearer and clearer.

Usually between four and six days after the Fast begins, the person feels better than ever before, free of any symptoms caused by (suspected) food allergies/sensitivities. Occasionally, it may take ten days, or rarely, even longer. The maximum length of time I have taken a patient through a fast is thirty six days - without harm!

Ultimately, of course, the Fasting mechanism breaks down, symptoms of starvation return, and the patient may die.

The difference between Starving and Fasting is very simple. Starvation is not a survival mechanism. Obviously, if a person is deprived of food, feels worse and worse, without relief, then that person loses the capacity to find new sources of food. Fasting then is very much a survival mechanism. It allows the person, in primitive times, to use his/her full intelligence to find those new sources of food.

However, there are two additional bonuses that come with Fasting.

Most of the great world religions have their origin in a Fast undertaken by one, or more, of the founders. For example, in the Bible, Jesus is baptized by John the Baptist. He then goes into the wilderness and Fasts for forty days. At the start he is tempted by the Devil - which I believe symbolizes the first 48 hours of Fasting. He puts the devil behind him (getting better as the Fasting mechanism activates), develops an extraordinary mental clarity and insight into human affairs, and embarks upon his ministry. History records what happens thereafter.

For medical purposes, Fasting has the bonus that it is a simple, safe (when supervised by a doctor knowledgeable about fasting), and effective way of coming to grips with the various problems that are caused by known, or merely suspected, food allergies. These problems include some of the most serious mental illnesses.

How to Fast

1. Make up your mind that it is necessary, and that you need to stick with the Fast through thick and thin, good and bad.
2. You take nothing at all by mouth except water.
3. No food!
4. No drinks but water.
5. No candies or chocolates.
6. ABSOLUTELY NO CIGARETTES!!!
7. No toothpaste.
8. No cosmetics.
9. No flowers.
10. No consumable gifts.
11. Plenty of spring or mountain water (if not available, then bottled), at least three liters per day.
12. Plenty of physical and mental activity:
 - a) if Fasting at home, continue normal routine and take extra walks of at least two miles per day.
 - b) if fasting in a hospital, walk around as much as possible (not to the tuck shop) and make frequent use of the exercise equipment in the Physiotherapy Department.
13. Twice daily showers or baths.
14. Twice daily warm water enemas, especially if symptoms are severe. This may be omitted from home Fasts, especially if symptoms are not severe.
15. Expect that the first 48 hours will be the worst, and increasingly severe before there is any improvement.

But, once you have successfully completed the Fast, remember that this is only the first step. If you do nothing further, you will soon lose all the ground that you have so courageously gained through the Fast. Unless you go on to testing yourself, it was pointless to do the Fast.

The really important part lies ahead - the Provocative Food Testing.

Provocative Food Testing - Preliminary List

This list is designed to be used only after the patient has successfully passed through a Therapeutic fast, and is free of ALL symptoms.

The testing is carried out by exposing the patient to ONLY ONE new food substance at a time, eating or drinking it, the time being most conveniently mealtimes.

If there is a reaction, this will be felt as a return of any, or all, or any combination of the patient's symptoms, OR a rise in pulse rate, between 20-30 minutes after trying the food, of greater than ten beats per minute over the rate at the time the food was taken - where there is no other explanation of that rise. Very rarely, reactions may be delayed for up to 60-90 minutes.

No reaction will last for more than an hour or so.

From these reactions (or lack of) two lists are built up. The first list consists of those foods to which a reaction took place, and which should be avoided whenever possible thereafter. The second list consists of those foods to which no reaction occurred, and which can be safely taken at any of all of the following meals. All mealtimes following a Fast should be considered testing; sessions.

The List

(Numbers in brackets refer to Notes below.)

Milk(1)	Coffee	Tomato
Bread(2)	Tea	Carrot
Corn(3)	Sugar	Celery
Eggs	Salt	Broccoli
Bacon(4)	Pepper	Cucumber
Apricots	Pineapple	Raspberries
Cheeses(5)	Peanuts	Cauliflower
Beef	Peas	Zucchini
Chicken	Rice	Apple
Turkey	Potato	Pear
Fish(6)	Lettuce	Orange
Cherries	Peach	Strawberries

Notes

1. One glass of milk is representative of all dairy products, and anything to which dairy products have been added.
2. Two slices of bread, representative of all wheat products, and anything to which wheat has been added.
3. Corn is added to many things, tablets in

- particular, and many brands of Vitamin C.
4. Ham can be used instead; neither should be sugar cured.
 5. Even though you test against dairy products and do not react, you cannot assume that you do not react to cheese. Each of the cheeses should be tested individually.
 6. Each kind of fish, shellfish especially (allergies to these can be life threatening), should be tested individually.
 7. The actual order should be varied according to circumstances and convenience.
 8. Foods not on the list which are particularly liked, and taken often, or disliked, and taken rarely, should be added to this list because there is a strong possibility that these are the most likely offending foods.
 9. Care should be taken that only one new food is added at each meal time so there is no confusion at all over which is the substance that might be causing the trouble.
 10. The list is only preliminary and just forms the basis for detailed and life-long testing.
 11. This is not a Scientific exercise, but a tool for long term change in lifestyle. Like real life it is a matter of trial and error.
 12. If you start deteriorating again, something has been missed. There is no problem about fasting again until you become well again. Then you can backtrack on the testing until you have found what was missed.
 13. Foods may occur in combination. It is vital to become knowledgeable about what is actually in what you eat. The unsuspected ingredient is what may be making you ill. Where you are in any doubt, leave it alone.
 14. What makes this horribly difficult is that you may be reacting to other environmental factors as well. These include pollution from nearby industry, such as pulp-mills, fumes from floor cleaning chemicals or paint, scents in cosmetics worn by visitors, contaminants in the water supply, molds, spores, pollens, animal dander, and infections (Candida being especially important). Too much artificial light can be harmful, or too little sunlight. **MOST IMPORTANT OF ALL IS CIGARETTE SMOKE.**
 15. If too many foods are found to cause reactions for avoidance to be possible or practicable, or something(s) are being consistently missed, then there are alternative approaches possible.
 - a). Referral to a knowledgeable dietitian who has experience with "Rotation diets" can be made.
 - b). Referral to an allergist interested and experienced with the "Rmkel Method" can be made. These are quite rare.
 - c). Referral to a medically qualified "Clinical Ecologist" can be helpful, but these are few and far between.

Once the preliminary list has been gone through, I can supply a more general list. But this is not a list of all possible foods. It is a general guide to further testing, and other foods should be added to it as they are encouraged. Good luck!

While this may be undertaken at home, some CFS patients may feel too sick to try this except under more close medical supervision in hospital.

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