8.0 Chronic fatigue syndrome

Introduction

- Chronic fatigue syndrome (CFS) is an acquired multi-system illness.[1,2.] It is common in adolescents following a viral illness (particularly EBV), however, it may present without a preceding illness.[1,2.] The symptoms are wide ranging but the primary symptom is overwhelming fatigue, for more than 3 months, which is not relieved by sleep. [1,2,3,4,5.] Patients also have some of the 8 symptoms for CFS;
- post exertion malaise lasting > 24 hours
- unrefreshed sleep
- significant impairment of short term memory or concentration
- muscle pain
- multi joint pain without redness or swelling
- headache
- sore throat that is recurring or frequent
- tender cervical or auxiliary lymph nodes.[1,2,3,4,5.]
- There is a wide range of impairment of function, with some patients being severely debilitated.[1,2,3,4,5] School non-attendance is common.[1,2,4.] CFS and depression can co-exist, and separating out the primary problem can be extremely difficult.[1,2,4] Depression can cause similar symptoms to CFS, and depression commonly develops in patients with CFS and there is also an overlap with anxiety disorders.[1,2,4.] CFS is a frustrating condition to live with and recovery may take many months.[1,2,5.] As a result, it is not uncommon for families to seek alternative therapies and investigations.[1.] A structured rehabilitation program with multi-disciplinary input promotes recovery.[1,5.] Once the diagnosis has been made, it is important to reduce the focus on further medical investigations and to develop a management plan to help ease symptoms and promote recovery.[1,5.]

Pre-referral investigations

- FBC & film, iron studies, UEC, CRP, ESR, coeliac serology, EBV serology, TFT
- Other investigations (e.g. H. pylori serology, ANA/RF/ENA) should be ordered if associated features such as rash, abdominal pain, nausea and vomiting or joint symptoms indicate the possibility of other diagnoses.
- Generally, rheumatological investigations are not helpful unless there is evidence of arthropathy/autoimmune disease. In particular, an isolated raised

ANA is reasonably common in the general population and does not aid diagnosis.

Pre-referral management

It is important to see the young person on their own and take a thorough psychosocial history to screen for depression, anxiety, bullying, school problems and family dysfunction. We suggest using the adolescent HEADSS screen:

Home

Education

Activities

Drugs & alcohol

Sexual health

Suicide / self-harm

Difficulties identified may all contribute to the presentation and will need to be addressed.

When to refer

Any adolescent with symptoms of CFS in whom there is a significant impact on social, family or school function.

Related policies, procedures, protocols and guidelines

List and hyperlink the titles of related policies, procedures and guidelines.
Canadian Expert Consensus Panel Criteria for ME-CFS.mht

References

1. Myalgic Encephalomyelitis / Chronic Fatigue Syndrome: Clinical Working Case Definition, Diagnostic and Treatment and Guidelines. A Consensus Document. Carruthers B.M, Jain A.K et al. *Journal of Chronic Fatigue Syndrome* 11 (1): 7-115, 2003.
2. Chronic Fatigue Syndrome (CFS) Fact sheet, 1-4. www.betterhealth.vic.gov.au
3. Chronic Fatigue Syndrome. Davis, CP, Balentine JR. MedicineNet;2013 [cited 2013 Oct 31] Available from: http://www.medicinenet.com/chronic_fatigue_syndrome
4. http://www.cyh.com/HealthTopics
5. Chronic Fatigue Syndrome. http://www.cdc.gov/cfs 2012

File Name and Path:	Chronic Fatigue management guideline		
Document Owner:	Dr Adelaide Withers, Charlotte Allen DPAM CNS.		
Reviewer / Team:	DPAM		
Executive Sponsor:	Executive Director Medical Services		
Date First Issued:	November 2013	Version: 1	
Last Revised:		Review Date:	November 2015
Endorsed by:	Medical Advisory Committee (MAC)	Date: October 2013	
Standards Applicable:	NSQHS Standards: 		
The accuracy of this document is not guaranteed when printed			