Dear members and friends of Massachusetts CFIDS/ME & FM Association,

I'm writing a special letter to give you my personal impressions from the October meeting of the Chronic Fatigue Syndrome Advisory Committee (CFSAC). Dr. Alan Gurwitt was invited to represent our Association at the meeting by participating in a one-hour panel of patient associations, the second CFSAC meeting which has included reports from groups such as ours around the country. I accompanied Dr. Gurwitt to the meeting, and we were present during all 16 hours of the meeting. Dr. Gurwitt will have his own report. We thank the Board of the Massachusetts CFIDS/ME & FM Association for making this trip possible.

Many of you may have watched all or part of the 2-day meeting via the live video cast, so you will have your own impressions.

First let me say that I am not a CFSAC expert, as I know many of you are, so apologies in advance if my observations and comments may seem a bit naïve. I am trying hard to learn and be able to put the deliberations in the proper context. You can read the meeting summary from a more experienced CFSAC observer here
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CFSAC Background

For those who are not familiar with CFSAC, it is a federal-level government committee composed of 10 appointed, voting members from the clinical and research communities, along with one appointed advocate who represents the Myalgic Encephalomyelitis (ME) and Chronic Fatigue Syndrome (CFS) patient community. The medical experts may not be ME/CFS experts, but they do have experience which bears on ME/CFS, and are expected to bring their individual perspectives to ME/CFS issues. Biographies of Committee members are not posted on the Committee's web page, nor are the selection criteria and process made public. Advocate Jenny Spotila has done some research into this and you can read about it here
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There are ex officio members of the Committee (non-voting) who represent various federal agencies whose work affects ME/CFS patients. These agencies may respond directly to the recommendations, or simply provide background information and guidance which may be

helpful to Committee members. Each agency representative gives an update at each meeting.

CFSAC's purpose is to "provide advice and recommendations to the Secretary of Health and Human Services (HHS), through the Assistant Secretary for Health (ASH), on issues related to Chronic Fatigue Syndrome (CFS). The issues can include factors affecting access and care for persons with CFS; the science and definition of CFS; and broader public health, clinical, research and educational issues related to CFS." You can read more about CFSAC's charter here .

The 2-day agenda is posted in advance on the CFSAC web page and with only one exception recently the meetings are live-streamed and also have an audio-only "800" call-in number so the public can observe the deliberations. The video cast, slides, minutes, and recommendations are made available on the CFSAC webpage after the meeting (much later, between 30 and 90 days later).

The Agenda

This meeting's agenda included 4 one-hour keynote topic presentations, 3 hours of public comment/testimony (increased by 1 hour as of this meeting), and the one-hour panel featuring reports from 4 patient associations (the second meeting that has included this), along with the agency updates and some time for Committee business, such as discussing what recommendations would come out of this meeting.

Notably missing from the agenda is a review of past recommendations and updates on actions taken in response to the recommendations. No status on the set of recommendations from last June's meeting was reported. The response from the agencies on the June recommendations is still winding its way through the bureaucracy and long list of approvals, but we were told it should be ready soon. (Note that the response to the recommendations of the Nov 8-9, 2011 meeting was dated August 3, 2012.) Not providing the response (however belatedly) during a meeting prevents discussion and questions, which contributes to the feeling of frustration expressed by some Committee members about how effective this process really is.

Recommendations from past individual meetings are posted on the CFSAC page (but not promptly), and a
summary of all the Committee's recommendations since 2004 and action taken

(or lack thereof) is also posted, but was last updated in 2011. Of the 65 recommendations made by CFSAC since 2004, progress is reported on 37, no progress has been made on 21 and there is no indicator provided for the remainder. (Note that the same recommendation may have been made at more than one meeting.) 29 of the 65 are reported as “completed” but I suspect that patients and advocates would disagree that some of these are finished (for example, educating health care providers on the treatment and management of ME/CFS, or discovering the etiology and biomarkers for the illness). Patients and advocates might also disagree with how some of the recommendations have been fulfilled, e.g. “Provision of updated web-based guidelines for CFS management given our current state of knowledge and expert opinion” (see CFS Toolkit as an example of a "finished" product ME/CFS advocates would like to see removed). **Reviewing progress on past recommendations in a public forum would hold the agencies more accountable for their work.**

Major topic areas

Four major topics were presented at the meeting:

- Biomarkers
- FDA and Drug Development
- Social Security Administration – Disability process with data for ME/CFS patients
- ME/CFS Case Definition – A Path Forward

Biomarkers.This was a scientific presentation by two members of the Committee. Although I have a science background, I regret to say that I was unable to follow all the details. My take-aways:

- several biomarkers have already been identified in research labs, and although they may not be exclusive to ME/CFS they do denote abnormal functioning of body systems;
- the search for biomarkers will be greatly enhanced by careful selection of patients according to well-defined criteria (“phenotyping”), and results from mixed populations are not as useful;
- the collection of samples used in the Lipkin study which have been made available to other researchers constitutes a very valuable resource for biomarker (and other) research;
- use of “big data” analysis has yielded promising results in similar studies in other conditions with mixed origins, such as Chronic Pelvic Pain Syndrome; the ME/CFS community is making progress through various separate initiatives in making available large amounts of data which could be used in such research, though the effort is not as coordinated as that for the Chronic Pelvic Pain research, which received a large NIH grant for this purpose.

FDA and Drug Development. Actions by ME/CFS advocates have had a direct effect on the FDA, specifically in expediting the process of moving potential drugs through the FDA approval pipeline. The FDA has been responsive to requests for meetings with advocates, and has set up several conference call meetings. However at present there is only one drug in the active pipeline for ME/CFS, and that is Ampligen.

One important job of the FDA is to review clinical trials, and an important component of clinical trials is the development and definition of “outcome measures” – that is, how can one determine if a drug had a positive effect, and to what degree. Appropriate measures of outcome may differ by subgroups of ME/CFS patients (for instance, an anti-viral may have a different effect for those patients who experienced sudden onset following a flu-like illness, vs. those who had a gradual onset), so the selection criteria used for patients participating in the trial is also very important. There is much more work to be done in this area.

An important limitation is that the FDA can only approve drugs which are submitted to it; the FDA cannot go out and develop new drugs on its own, nor force commercial companies to work on drugs to treat a specific illness. However, they do review applications for new uses of already-approved drugs (“re-purposing”) so this type of application, if submitted, could be expedited. Note that patient outcomes for nutritional supplements and other alternative remedies are not subject to FDA review.

Social Security Administration – Review of Disability Process for ME/CFS Patients. This presentation was a detailed review of the disability application/review process for individuals with a diagnosis of Chronic Fatigue Syndrome (or similar condition) by Arthur Spencer, Association Commissioner, Office of Disability Programs, SSA. The 5-step process and criteria for ME/CFS have not changed since 1999, when a special ruling was prepared for CFS (SSR-992P), and there is a good
description of the disability application process on the CDC site
. A special note is that Mr. Spencer said that the Social Security Administration did not require a diagnosis according to any particular case definition, which is contrary to the generally accepted principle that the diagnosis must be made in accordance with the 1994 CDC definition (see our
Disability Handbook
).
This was an important presentation for patients who may be considering applying for disability benefits. We will alert you when the video cast is available on the CFSAC website.

Interesting data was also presented. Key points:

- The “allowance” (approval) rate for ME/CFS is lower than for other conditions (21% vs 33%).
- The disability process for ME/CFS patients is long (averaging 2 years) and because of the nature of the illness it commonly is not decided until at least Step 4 or 5 of the process.
- It is also common that ME/CFS patient applications are rejected initially and upon the first appeal. A second appeal (a hearing before an Administrative Judge) is often when the “allowance” is granted (70% of ME/CFS applications that reach this stage are “allowed” by the judge, 2008 data).
- New applications from ME/CFS patients averaged above 1500 per year for the period 2002-2009, but the number of applications dropped to under 1000 in 2010 and 2011 (827 applications in 2011). No speculations or reasons were offered for this.
- The importance of keeping a “daily diary” of activities (or inability to perform normal activities) was stressed as a critical piece of evidence to support the disability application. Such mundane-seeming facts as whether one was able to make breakfast for the kids become very important.
- Although a disability allowance is never intended to be permanent, in reality, budget constraints have prevented the Agency from doing much review as to whether a patient’s condition has improved over time so that they could be able to work and no longer would qualify for the disability payment.

ME/CFS Case Definition – A Path Forward. This discussion largely centered around whether the Committee could make a recommendation or help to encourage a consensus on which case definition should be used for ME/CFS, recognizing the limitations of the various case definitions now in use. There was a strong sentiment to follow the IACFS/ME in endorsing the 2003 Canadian Clinical Case Definition, at the same time recognizing that for purposes of research, patients meeting this diagnosis might need to be further sub-divided according to their actual symptom pattern, type of onset, degree of severity of the illness, or other factors.

Subsequent discussion centered on the wording of a possible recommendation in this area. Dr. Nancy Lee, the Designated Federal Officer for CFSAC, pointed out that the government cannot and does not tell clinicians and researchers what to do, and that the most effective action would be to facilitate a meeting or workshop of key clinicians and researchers who would then determine among themselves an “expert” consensus which could then be disseminated through them to their own communities. Discussion ensued as to whether a broad group across medicals specialties should be invited, or only ME/CFS “experts”; and if only experts, whether that group would be able to lead a general acceptance of their recommendation within their medical specialties.

Public Testimony

The 3 hours designated for public comment consisted of 5-minute presentations (submitted in advance and selected by the meeting organizers) from patients and advocates, representing a wide range of experiences, and often making direct requests of the Committee. For the most part these were listened to attentively but without comment. The notable exception was a moving statement regarding the degree of hopelessness and despair that drives patients to consider ending their lives rather than continuing their day to day existence. The Committee chair gave the members a chance to discuss and respond to what they had just heard before continuing with the rest of the comments during that hour.

Each of the presenters had important things to say, and it is critical that the Committee members continue to hear from the public regarding the impact of ME/CFS on their lives. We thank our own Donna Pearson for presenting her testimony as part of the Public Comment.

ME/CFS organizations

Our Association went first (see Dr. Gurwitt's text and slides), followed by CFS Solutions of West Michigan (now PANDORA), the Wisconsin CFS Association describing their Health Co-Op Project, and IACFS/ME presenting their current initiatives. We were able to distribute our "Pediatric ME/CFS: Resources for Patients, Families and Clinical Practitioners" CD to all the committee members, to Dr. Beth Unger of the CDC who attended our presentation, as well as to the ME/CFS advocates who were in the audience. We are hopeful that the resources collected on this CD will help educate Committee members as well as provide a head start for those who are responsible for preparing educational material for pediatric ME/CFS which is planned for the CDC website. The format and content of the presentation to the Massachusetts School Health Institute 2012 can also serve as a model for any state/regional association that would like to produce a similar session in their area. We also offered to make our proposal available to others.

The Committee will hear from other patient organizations at subsequent meetings; however no government funding support is provided for this. We are grateful to our Board for supporting this trip to give our Association the opportunity to present our work in Massachusetts to the Committee.

Agency Updates

The various agencies presented updates, reporting on their progress since the June meeting.

Also they took the opportunity to clarify their roles and what they can actually do, which is not always what we might wish they could do. We personally got a better sense of how government agencies actually work, which is for the most part slowly and carefully, and according to rules which impose some limitations. We also got a better sense of the many “catch-22s”, such as NIH can only consider funding applications it receives, and it doesn’t fund many ME/CFS applications because not many are submitted because so few are funded and for such small amounts. Likewise, new researchers don’t come into the field because of the small number of grants funded, and the number of grants funded is small because there are so few researchers submitting grants.

CDC (Centers for Disease Control and Prevention). The CDC reported on a series of educational initiatives (CME courses, Patient Vignettes for medical schools via the Med Ed Portal). In addition, the CDC has instituted a series of public conference calls (2 per year), with each featuring a 20-minute presentation from an ME/CFS expert. During these calls the CDC will give a status update, as well as respond to questions from callers submitted in advance. The first call occurred in August, and no date has been announced for the next. Although these are intended to be “outreach” calls, there is no live interaction with participants during the call; it is one-way communication only.

One HUGE disappointment was the CDC’s decision not to remove the link to the Toolkit, despite the Committee’s clear and unambiguous recommendation to do so. No explanation was given for this decision. Dr. Unger stated that the Toolkit would be revised, but provided no details and no timeline. Committee members did not press for this, which was a bit surprising.

FDA (Food and Drug Administration). In contrast, the report from the FDA offered helpful information on how to better work with the agency and negotiate the clinical trials/drug approval process. The FDA will be offering a webinar on November 15, 2012 titled “Excellence in Advocacy” to help advocates learn the tools needed for effective advocacy for drug development, using examples from past successful advocacy efforts. The transcript of the FDA conference call with ME/CFS advocates which was held on September 13 was posted promptly on the FDA website.

CMS (Centers for Medicare and Medicaid Services). Ms. Alaine Perry has followed up on an earlier request from CFSAC to provide information on what tests will be covered by Medicare and Medicaid for patients with a diagnosis of CFS. This list is still in progress. Ms. Perry also described the process that would be used to review the decision if a particular test is not covered. Dr. Mary Ann Fletcher, a Committee member, provided the list of tests that are commonly recommended for patients in her clinic; we feel that the list of tests recommended in

the current version of the IACFS/ME CFS Primer for Clinical Practitioners should be submitted for review as well, and I have sent an email with this request to Ms. Perry with the list of tests from the Primer.

AHRQ (Agency for Healthcare Research and Quality). The Agency for Healthcare Research and Quality runs the National Guidelines Clearinghouse, a public resource for evidence-based clinical practice guidelines. At the June CFSAC meeting the suggestion was made to submit the IACFS/ME Primer to the Clearinghouse for possible publication on its website, guidelines.gov. This was done, and the Primer was accepted. The Primer is now in the process of being prepared for posting. This is a critical step, because government websites do not generally link to non-government sites. This was a reason cited for difficulty in linking to the Primer from the CDC site. However since guidelines.gov is a government site, this link can be used by other government sites to link to the Primer. Also, the agency has a mandate to publicize guidelines.gov to the medical community as a source of practice guidelines. We will notify our email list when the primer is available on guidelines.gov.

CFSAC Sub-committees

CFSAC has at least two sub-committees which met and made brief informal reports at the meeting. One is for Research; the other (I think) is Management and Treatment. I didn't get a clear picture of the structure and membership, or whether there are other sub-committees. It would be interesting to know more. I think that the sub-committee reports had some impact on the recommendations that were eventually made.

It would also be interesting to know whether/how the sub-committees and the entire Committee communicate or work between formal meetings.

Recommendations

A number of specific recommendations will come out of this meeting. I took some notes, but do not want to rely on my scribbles to pre-announce the Committee's final recommendations, which I gather will be put into final form over the next few weeks. What is more interesting to me than final wording are the results of the Committee's having made a recommendation, and I have to say that while it is always good to have hope, progress will likely be in small, measured steps rather than in giant leaps, and some recommendations, even those made repeatedly, will

result in no change at all.

Overall impressions

- Attending a CFSAC meeting in person was a wonderful experience and a great opportunity to meet and network with other ME/CFS patient advocates; we made some important connections. It is crucial that patients and advocates show up, despite the difficulty and expense. **Getting large numbers of people attending in person (50 would be wonderful) and viewing the live streaming or listening on the audio, is really, really important to impress the government agencies that patients are paying attention and to support CFSAC in its work for the community.**
- The Committee members are engaged and attentive to the issues, and all are impressive individuals, though some are quieter than others. The ex officio members are all good representatives of their respective agencies. However the agencies differ in their response to ME/CFS. The CDC in particular, despite having made many positive steps recently, still has a way to go. The agency representatives often appear to be walking a very fine line between being committed and helpful, and complying with restraints and constraints inherent in their positions within their agencies.
- The sole patient representative on the Committee, Eileen Holderman, is doing a fantastic job representing patient views and interests. She will be helped in this role when, sometime in the future, 3 patient-advocate liaisons are added to the Committee. As a side note, the process for implementing this (required by the recent CFSAC charter revision) was not discussed at the meeting.

Finally, we intend to stay in communication with CFSAC and with the CDC in particular about the Toolkit recommendation.

If you would like to stay informed about CFSAC activities, you may sign up for the CFSAC mailing list .

We applaud the Committee members for their support of ME/CFS patients, and for their ability to stay engaged despite obvious frustrations. We also applaud the many patients and advocates who participate in these efforts, not only around CFSAC meetings but every day.

Charmian Proskauer, President
Massachusetts CFIDS/ME & FM Association