**Literature Review on Chronic Fatigue Syndrome**

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More than 17 papers connected to chronic fatigue syndrome were picked from computer-based research as well as relevant articles highlighted in the references to analyze the literature on chronic fatigue syndrome, particularly as it pertains to communities with problems and exercise (Shafran, 1991). CFS is a contentious diagnosis of exclusion; however, it appears that there are subgroups. Furthermore, it frequently represents various phases of the same illness. Although cognitive deficiencies are commonly reported, the measured impairments are usually minor, affecting sophisticated information processing speed or efficiency (Suh et al., 1998). Chronic fatigue syndrome, on the other hand, is a long term condition that affects a variety of bodily systems. CFS is often referred to as myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS). As a result, this research analysis aims to present a case study analysis on the topic of chronic fatigue syndrome. CFS produces inflammation in the brain and spinal cord and muscular trigger sites that generate discomfort.

For someone suffering from CFS, typical day-to-day activities will result in lengthy periods of bed rest. Between the ages of 40 and 60, American adult women outnumber adult males as the most prevalent age group. On the other hand, CFS can afflict people of any age group, including toddlers and teens, and symptoms may appear gradually over months or years (Lim et al, 2020). A viral infection, chemical exposure, vaccination, and trauma can aggravate the disease. Physical and mental exhaustion exacerbated by physical and mental activity that occurs 50% of the time or more and lasts at least six months is a poorly understood condition characterized by physical and mental exhaustion exacerbated by physical and mental activity that occurs 50% of the time or more and lasts at least six months.

Various physical and psychological symptoms, including myalgia and despair, accompany the weariness. Chronic tiredness has an unclear outlook. The lay literature, in particular, indicates a lifelong path with only sporadic recovery wine lists at the point where recovery is the norm (Rasa et al., 2018). Chronic fatigue syndrome (CFS) is the more frequent and milder subsyndromal counterpart of CFS, characterized as extreme exhaustion that occurs 50% of the time for at least six months but is not always accompanied by functional impairment (Price et al., 2008). Given the differing perspectives on prognosis and the limited sample sizes of much research, we systematically assessed all studies that followed people with chronic fatigue (Afari, 2003). The purpose of this research is to summarize the prognosis of tiredness states in terms of the proportion of people who improved throughout each trial and any events such as increased medical illness or fatalities that were observed.

**Methods**

**Study Selection and Literature Search Strategy**

Papers published in English language peer-reviewed journals during 2016 have provided any clinical follow-up data following an ascertainment due to an initial diagnosis of CFS are identified from four databases. On the other hand, the study strategy was chronic tiredness or any chronic fatigue syndrome (Komaroff, 1998). In the title and abstract, all references were double-checked. Papers that employed a combination of goal symptoms, such as weariness and pain, were the key excursion criterion. Surprisingly, publications with a major focus on biological or psychological therapeutic research or current treatment. Papers that feature placebo groups of patients enrolled in randomized controlled trials were included.

**Data Extraction**

The case study's data was collected using a standard form. Naturalistic studies, which monitored groups of CFS sufferers over time, were categorized according to their design, which fell into three broad groupings. Comparative cohort studies compared the outcomes of CFS patients who died of another illness to randomized controlled studies in which people were assigned to placebo groups. Additional information was recorded about the sample's socio-demographic features, the study's inclusion criteria, the key outcomes used, and the environment. However, because the studies tended to utilize various outcome measures, a comprehensive set of standards was needed to compare the findings (Maksoud et al., 2020). Obtaining information on the number of people who met each of the following criteria was typically achievable. The options were: recovered or better, same, worse, and death.

Most investigations employed a variety of standardized morbidity measures, but the result was a global assessment of weariness for the entire group (Wessely, 1995). When it was applicable, information on additional metrics was recorded. Overall objective functional and symptomatic particular evaluations were not available in all but one trial for the whole group. The number of individuals who received a new organic or mental diagnosis, as well as any treatment details, were recorded during the course of the study's duration. (Cleare, 2003) Finally, any conclusions on outcome determinants were indicated. The data is given according to the study's context, whether it tracked children or adults, and the definition of CFS utilized.

**Participants**

The research examined both males and females together with adolescents and children. Besides, the total number of people present was 2075. The test sample of the participants with CFS were medically evaluated.

**Case Study 1 Patient**

**Female Age:** 62

**History:** In 1989 she became sick and reported trouble sleeping. In the mid-90s developed adrenal fatigue and blood sugar issues. She had numerous blood tests which were completely normal. She reported that after one hour of gardening she was in bed for six hours to recover and incapacitated the following week. sDiagnosed with chronic fatigue in 2013, shortly after having some amalgam and teeth removal. Trouble with mental focus, anxious, and high strung.

**Treatment/Method:** September 2020 started taking Proprietary blend 1, 4 drops B.I.D.

**Results**: After 2 months, she reported the following: food sensitivities abated, more energy, better focus and concentration, histamine intolerance alleviated, knee pain alleviated, and blood sugar stabilization.

Follow up in 6 months.

**A Diagnostic Journey: The Reclassification of ME/CFS Across Decades**

Since the initial outbreak of Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS), in Los Angeles in 1934, the condition has experienced a number of modifications in terms of nomenclature and case definition. In the 1860s, Dr. G. Beard first described the ailment in his book and coined the name "neurasthenia." Later, during the UK outbreaks, the characteristics of neurologic symptoms led to the condition being dubbed 'benign ME,' and Ramsay produced the 'ME' case definition in 1986 (Cortes et al., 2019). When subsequent outbreaks proved the sickness was caused by a viral infection, the disorder was termed 'chronic Epstein-Barr virus syndrome (EBVS)' in 1982 and 'postviral fatigue syndrome (PVFS)' in 1985. Due to a lack of evidence linking the virus to the illness and numerous sporadic cases in the general population, the Centers for Disease Control and Prevention (CDC) adopted the term "CFS" (Holmes definition) in 1988 to more broadly identify the symptom complex, which included mental symptoms.

In 2003, the Centers for Disease Control and Prevention (CDC) published the 'ME/CFS' criteria, which encompassed both 'ME' and "CFS" clinical symptoms. On the basis of the notion of neuroinflammation, the term "ME" or "ME/CFS" was coined. Before recently, the labels ME, CFS, and ME/CFS were all used to refer to the same condition. The International Classification of Diseases (ICD) system exemplifies the complexities of such confusing terms in their complexity. The World Health Organization categorized the disorder as a neurological illness in 1969. (ICD-8 number 796.0). Despite that, the ICD-10 (2016) categorized it as PVFS (code G93.3), which only indexes 'benign ME'—the term 'benign' was dropped from the 2019 edition due to its lack of relevance. This is because 'CFS' was not labeled here, doctors frequently used the codes R53 for malaise and tiredness, F48 for fatigue syndrome, and even neurasthenia for neurasthenia. However, in the most recent edition of the ICD-11 (2019), PVFS (code 8E49) classifies both '(benign) ME' and 'CFS' as distinct illnesses, with tiredness (MG22) being excluded. As a result, ME/CFS is poorly defined, despite the fact that the idea of 'CFS' has evolved from 'fatigue,' and despite attempts to classify the illnesses (ME and CFS) under a single ICD code, the syndrome remains poorly defined (Patarca, 2001). Misclassification of the condition as psychiatric or predominantly fatigue-related problems has also contributed to misunderstanding the words.

Dr. S. Freud, a psychiatrist who thought sickness was induced by unresolved conflicts in the unconscious mind. Similarly, he coined the term "neurosis," which was meant to presume that the illness was psychiatric in nature, as opposed to the original term "neurasthenia," which was meant to denote an organic neurological ailment. Similarly, in the 1970s, McEvedy used the term "myalgia Nervosa" to suggest a psychiatric etiology (Joyce et al., 1997). Until recently, the cause of sickness (psychological vs. neurological) appeared to be a contentious issue. Between 1987 and 2013, around 20% of media reports in the United States incorrectly categorized ME/CFS as a 'fatigue or psychosomatic-related syndrome,' thereby trivializing the illness. It is now classed as a difficult multisystem neuroimmune illness, which means it affects several systems. The International Organization for Standardization (IOM) proposed a new name, SEID, and related criteria in 2015, eschewing the stigma associated with "fatigue" and instead concentrating on the fundamental symptoms that present systemically as physical disease.

**Characteristics of Sample Used**

The study's sample size ranged from 15 to 498 people. Only a few studies employed operational criteria for CFS, and they used a range of classifications (Lorusso et al., 2009). Cases were omitted from the rest of the survey in 8 cohorts if the beginning of tiredness was not clearly characterized elsewhere in the reminder. It was not mentioned if the onset was new or had occurred before. The inconsistency of case definitions substantially restricts the study's comparability. The bulk of the research took place in hospitals. Some studies merely provided a mean or median follow-up period, whereas others reported a range of durations. As one may assume, given the epidemiology of CF, there were more women than males in all of the studies that provided gender distribution. Four of the studies were limited to children and teenagers. In addition, four research featured mixed kid and adult groups, whereas 17 studies focused only on adults.

**Outcomes**

Only three of the 2075 patients tracked with organic exclusion in the 19 trials died. It is unclear if the vital status of nonrespondents was evaluated in certain research; therefore, the mortality rate might be higher (Missailidis et al., 2019). An unconnected physical disease caused one death, an unidentified reason caused another, and the third was caused by suicide.

**Findings**

The findings indicated a variety of complex and interrelated themes throughout the patient and physician narratives. ME/CFS is difficult to comprehend and treat for both patients and health care providers, which can lead to stigmatization and conflicts (Ranjith, 2005). According to the authors, future qualitative research should encompass several facets of the ME/CFS experience, members of ME/CFS networks, and the sociocultural context in which the illness is defined and studied (Anderson et al., 2012). Finally, the authors question the prevalent socio-cultural narratives surrounding academics' and physicians' views on ME/CFS and their victim-blaming tendencies. Failure to keep all parties accountable is harmful to both the patient population and the advancement of research and practice.

**Implications for practice**

Richman and Jason discovered a contradiction in which a considerable percentage of the medical establishment still credits mental and psychological reasons. In contrast, patients with ME/CFS generally ascribe their condition to a still unknown biological etiology from a contextual, feminist perspective (Whiting et al., 2001). Furthermore, patients with ME/CFS have been well-documented to face stigma from healthcare professionals, family, and friends. Given these considerations, additional qualitative research of persons with ME/CFS' self perceptions to understand marginalization experiences is needed. Qualitative research can provide valuable insight into patient experiences for health care practitioners. The ability to synthesize information provides for a more comprehensive description of the ailment and a more accurate diagnosis and therapy suggestions.

**Conclusion**

The literature review has highlighted the causes of CFS. Typically, Chronic fatigue syndrome, on the other hand, is a long-term condition that affects a variety of bodily systems. Myalgic encephalomyelitis/chronic fatigue syndrome is another name for CFS. CFS produces inflammation in the brain and spinal cord and muscular trigger sites that generate discomfort. For someone suffering from CFS, typical day-to-day activities will result in lengthy periods of bed rest. Between the ages of 40 and 60, American adult women outnumber adult males as the most prevalent age group. On the other hand, CFS can afflict people of any age group, including toddlers and teens, and symptoms may appear gradually over months or years. A viral infection, chemical exposure, vaccination, and trauma can aggravate the disease. On the other hand, the paper reviews the data collection and methods in gathering these research studies.

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