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Chronic Fatigue Syndrome
A Clinical Evaluation and Eastern Perspective on Treatment Options

Myalgic encephalomyelitis/ chronic fatigue syndrome, known commonly in Australia as ME/ CFS, is a complex, serious and debilitating condition characterised by extreme exhaustion, intolerance to physical exertion, sleep disturbances, cognitive dysfunction and pain. It "affects many parts of the body, including the brain and muscles, as well as the digestive, immune and cardiac systems, among others. ME is classified as a neurological disorder by the World Health Organisation"[1]. It has been known by a range of other names including "post viral syndrome, chronic Epstein Barr viral syndrome, myalgic encephalomyelitis (ME) and chronic neuromuscular viral syndrome"[2].

It is complex in part because there hasn't been a clear or definite aetiology for Chronic Fatigue Syndrome (CFS), and without that it is difficult to determine the diagnostic guidelines to apply, even harder to then know which treatment options to unfurl. Without diagnosis all clinicians are in the dark.

As a medical condition it can be profoundly debilitating, and yet for decades it was considered by many, both in mainstream medical circles as well as within the broader public, to be as much a psychological condition as a physiological one. And because of this, historically, it wasn't taken as seriously as it should have been.

Due in part to this response, and the way that a name can affect our expectations and understanding the Institute of Medicine (2015) have suggested that the label of CFS has so adversely impacted both patients' own perception and the broader society's understanding of the disease, that they believe a name change is required[3].

They maintain that the label of CFS can 'trivialise the seriousness of the illness and promote misunderstanding about it'. They have suggested it be relabelled "Systemic Exertional Intolerance Disorder (SEID), because as a name, it more effectively captures the characteristic nature of the disease; that exertion of any kind can adversely affect patients in multiple organ systems"[3].

While as Eastern medicine practitioners (Acupuncturists, meridian therapists and Chinese Medicine Herbalists) we are not 'disease name therapists'[4] it is worth being cognisant of both the new terminology and interesting to consider what is in a name, if only to remember, naming can be prescriptive and narrow our thinking too much. To consider the ways in which early thinking about a disease tends to set researchers and clinicians down a particular route from which it is difficult to return can give us insight into our own diagnostic thinking and assumptions. To avoid confusion, and to use the standard Australian terminology, ME/ CFS or CFS will be used in this discussion.

In 2007 there was a trial called "Protocol for the PACE trial: a randomised controlled trial of adaptive pacing, cognitive behaviour therapy, and graded exercise, as supplements to standardised specialist medical care versus standardised specialist medical care alone for patients with the chronic fatigue syndrome/ myalgic encephalomyelitis or encephalopathy". Otherwise known as the PACE trial.

"It showed that Cognitive Behavioural Therapy (CBT) and Graded Exercise Therapy (GET) gave moderate benefit in persons with CFS"[5]. Even now the most recent studies cite that CBT is a moderately useful therapy for ME/ CFS[6,7]. What they don't explain is why.

The weight of evidence from the PACE trial suggested that CBT was of moderate benefit to participants. This was due no doubt to it being a strategy that helped patients cope with the illness because the quality of life is so constrained. One of the characteristics of chronic illness, is that living with the illness can often lead to depressive symptoms.

It should be noted here that physical trauma (such as a surgery or a car accident) or physical, mental, or emotional stress may contribute *to the onset of the condition*[8]. This though is different to saying something is causative. And to this end the authoritative voice on ME/ CFS in the United States is at pains to point out that it is a medical condition and not a psychiatric or psychological one[3].

It is important to highlight the silence around this elsewhere. CBT is not a treatment for the illness itself, rather the complications of living with a chronic and debilitating illness. Following that logic, other forms of counselling and psychological support will assist also.

While the PACE trial has been widely accepted as good research and showed responses that indicated treatment possibilities, according to Bateman and Spotila (2013), even the "GET should be administered with great caution… because even mild exercise can provoke post-exertional malaise and severe symptom flare-up that correlate with gene expression findings"[9]. And yet GET too is still mentioned in the most recent literature about ME/ CFS as being of moderate usefulness as a treatment strategy.

If the disease had been called Systemic Exertional Intolerance Disorder (SEID) in the first instance, a decade before the trial, I wonder whether we'd even be considering both therapies as some kind of treatment strategy for it.

So, before we get to how we might think about it from an Eastern framework, let's have a look at the medical criteria sets for ME/ CFS because they will be part of our thinking about diagnostics and treatments and give an indication of what symptoms patients generally present with.

In the late 1990's the diagnostic checklist was extensive. There were major and minor diagnostic criteria. *The language of the checklist from that time is revealing in itself:*
"The Major Diagnostic criteria, of which both criteria must be met [were]:

1. New onset of persistent or relapsing debilitating fatigue (of muscular type) that impairs daily activity to below 50% of the premorbid level for at least six months.
2. Complete exclusion of other physical or psychiatric disorders that may produce similar symptoms".

"The Minor criteria, where either six symptoms, plus two physical criteria or eight out of the 11 symptoms had to be met, are listed as follows:

1. Mild fever
2. Recurrent sore throat
3. Painful lymph nodes
4. Muscle pain
5. Muscle weakness
6. Prolonged fatigue after exercise
7. Generalised headache
8. Neuropsychiatric complaints (poor concentration, confusion, excessive irritability, depression)
9. Migratory joint pain
10. Sleep disturbances
11. Rapid onset of symptom complex"[2].

These days, some 30 years on, the diagnostic criteria are more succinct; there is a reduced burden on patients to 'meet the list', less presumption of it being 'all in your head' and a recognition that it can fundamentally affect all areas of life, wellbeing and decrease living standards. Recent data shows that two thirds of 1000 surveyed participants lived below the poverty line[10]. A staggering burden primarily on women who already face considerable economic suppression and disadvantage[11].

The current United States guidelines for differential diagnosis within a Western medical model require:
"The patient has the following three symptoms:

1. A substantial reduction or impairment in the ability to engage in pre-illness levels of occupational, educational, social, or personal activities that persists for more than six months and is accompanied by fatigue, which is often profound, is of new or definite onset (not lifelong), is not the result of ongoing excessive exertion, and is not substantially alleviated by rest, and
2. Post-exertional malaise*, and

3. Unrefreshing sleep.

At least one of the two following manifestations is also required:
1. Cognitive impairment* or
2. Orthostatic intolerance".

"*Frequency and severity of symptoms should be assessed. The diagnosis of ME/ CFS (SEID) should be questioned if patients do not have these symptoms at least half of the time with moderate, substantial or severe intensity"[3].

"It is believed that many people with CFS don't know they have it, [which tells us that there are a lot of people pushing through fatigue and cognitive impairment] or it is yet to be diagnosed"[3], so we need to accept that even with all the available and current data, the full profile of the disease may still be unclear. We do know the following:

According to Yancey & Thomas (2012)[12] women are twice as likely as men to have CFS. According to Emerge Australia (2019) it is more like 75-80% of patients suffering from ME/ CFS are women[8]. It was usually thought to occur between the ages of 20 and 40 years of age[2], with onset often coming around the mid-thirties[3]. Onset in childhood, adolescence or older age is not unheard of within the literature however, and there are many who report that symptoms begin to emerge from the ages of 11 - 20[10]. The onset can be sudden or it can be gradual and the reason for why this is the case is not currently understood from a Western medical viewpoint. From an Eastern perspective, within its emphasis on individual constitutional factors, and pathogenic trajectories (the six divisions) and how the nature of disease is thought to progress, the answer to this could be well articulated with the diagnostic framework of lingering pathogens and the how it affects latency within the living human body.

"It is thought that approximately two out of every three patients with the illness follow a clearly defined viral illness, however no single virus has been consistently associated with the syndrome"[2], although Epstein Barr is often part of the clinical picture[3]. "Evidence from prospective cohort studies[13] indicate that up to 10% of patients with post-infectious syndromes develop CFS, regardless of the type of infectious agent"[9]. On their website, Emerge Australia (2019) states that "infection is the most common, but is not a universal trigger for the condition", with environmental toxins also being a significant factor[8].

"There are no diagnostic biomarkers or tests for ME/ CFS even now, however there are many biological abnormalities that researchers have found in people living with the condition"[1]. And while researchers and clinicians are always cautious about claiming a definitive aetiology of CFS, there are "peer-reviewed publications which support a physiologic aetiology of CFS"[9]. "These include an abnormal physiological response to exercise, altered immune function, changes in the bacteria in the gut, and impaired energy production". There are studies too, that suggest that there are genetic changes and markers that are part of the ME/ CFS profile[14] adding more weight to the notion that there are changes being wrought on the human organ systems that have a physiological cause.

At what point did Western medicine forget that a pathogen or combination of pathogens (virus, bacteria, parasite, etc.) might be able to wreak such damage on our bodies and our lives?

And this notion of a post-infectious syndrome is significant, because as Eastern medicine practitioners, it is the something we understand and treat pretty well. Within Chinese Medicine, "you are really studying different perspectives on how to look at the human condition through the lens of illness, and how to bring the individual back to a state of wellbeing"[15]. We call post-infectious syndromes lingering pathogens and have whole traditions devoted to its

Figure 1: Chronic Fatigue Syndrome

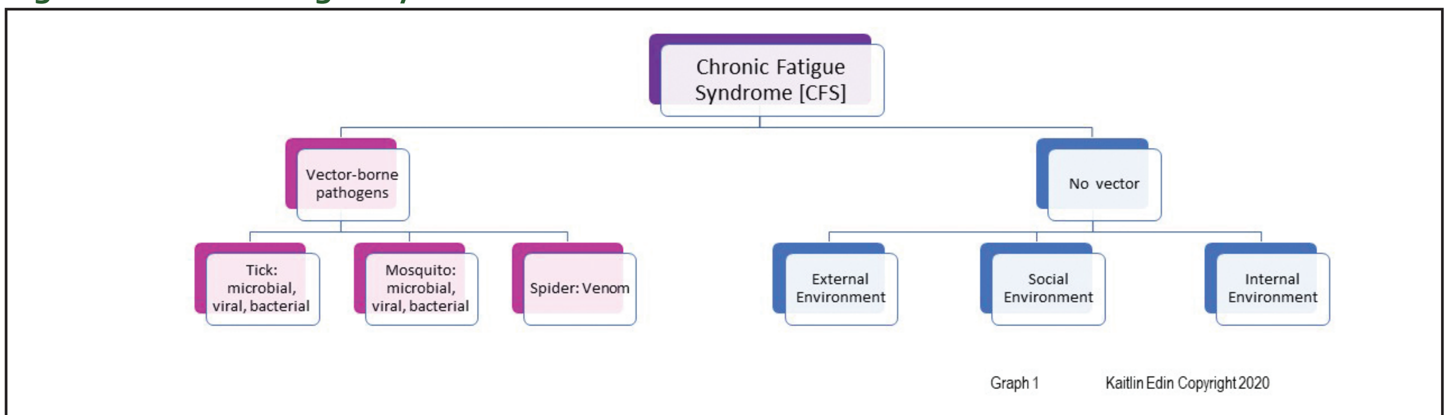
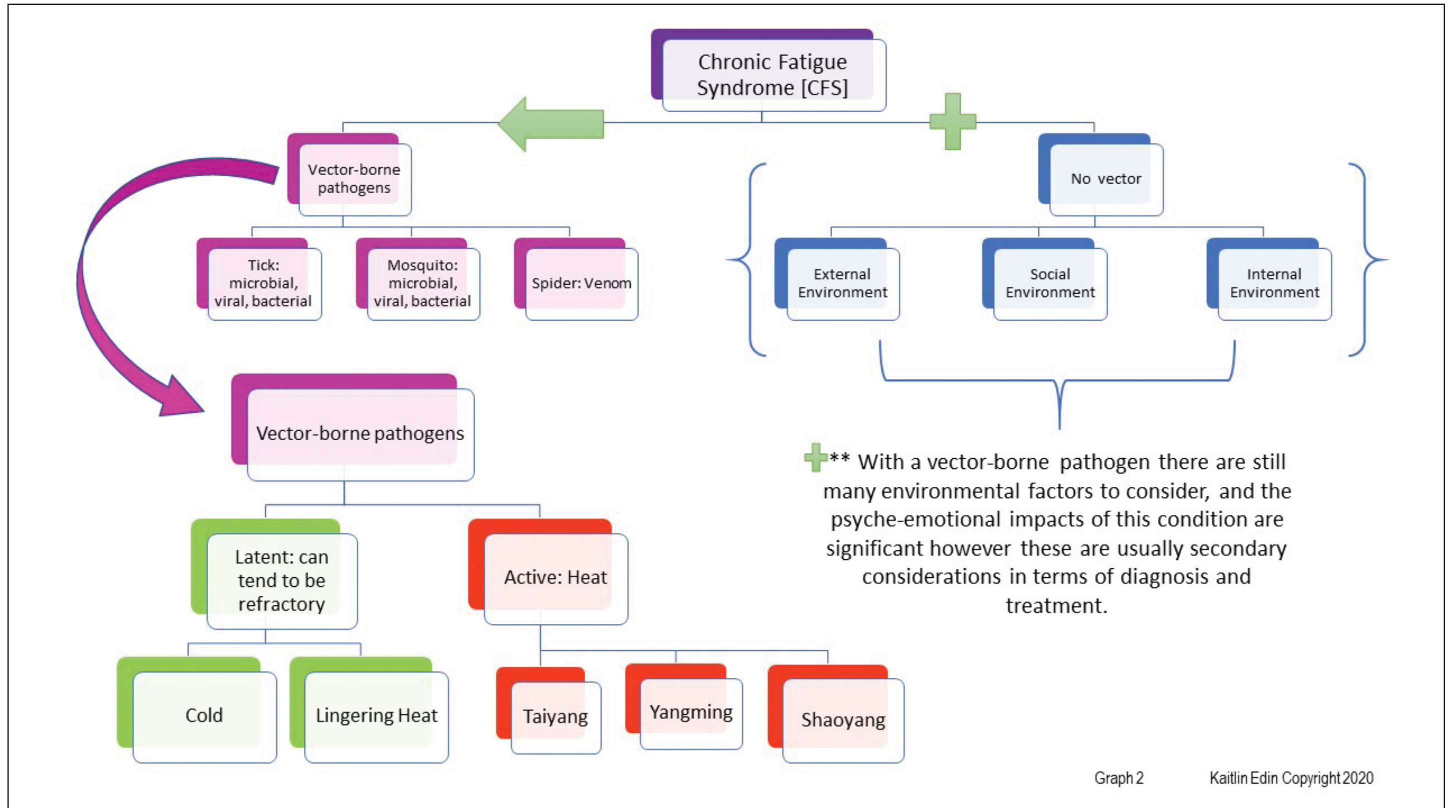


Figure 2: Chronic Fatigue Syndrome with a Vector-borne Pathogen



treatment. In this case, what is important is not what we call a syndrome or even its criteria but how we understand the constellation of symptoms and the treatment principle we use to address them.

The Shang Han Lun, a classic diagnostic and herbal treatment text outlines the extent to which the pathogens of cold, heat, dampness and wind affect the human body and its ability to recover. All these 'climatic' characteristics are terms that refer to both the external and internal worlds. They are alternative terms for things like fungi, viruses, bacteria, parasites, microbes. And in ME/ CFS it is possible that there is a constellation of these pathogens at work.

So let's try and find the dynamic at play here, let's come back to first principles and start by mapping out what we might know or see in the clinic.

Figure 1: We can start with the exertional and profound fatigue and a range of symptoms that we think resemble ME/ CFS. First, we need to consider or ask whether there is a possibility of an infectious agent (either latent or active). Has there been a vector-borne pathogen?

Tick, mosquito and less often spider bites can introduce a range of bacteria, microbes, parasites, viruses and toxins into the human bloodstream. We need to consider these extremely carefully. For example, while Lyme Disease is not recognised by the mainstream medical establishment in Australia[16] it is remarkably similar in its symptomology to CFS.

Figure 2: If there has been exposure to a vector like a tick or a mosquito, we need to consider whether it is still active or whether it has gone into latency. If it has gone latent, or it is a 'late stage' infection from said vector, then it is likely to be across multiple organ systems, and may well be refractory. Consider whether there is lingering heat in the system or whether it has gone 'cold'.

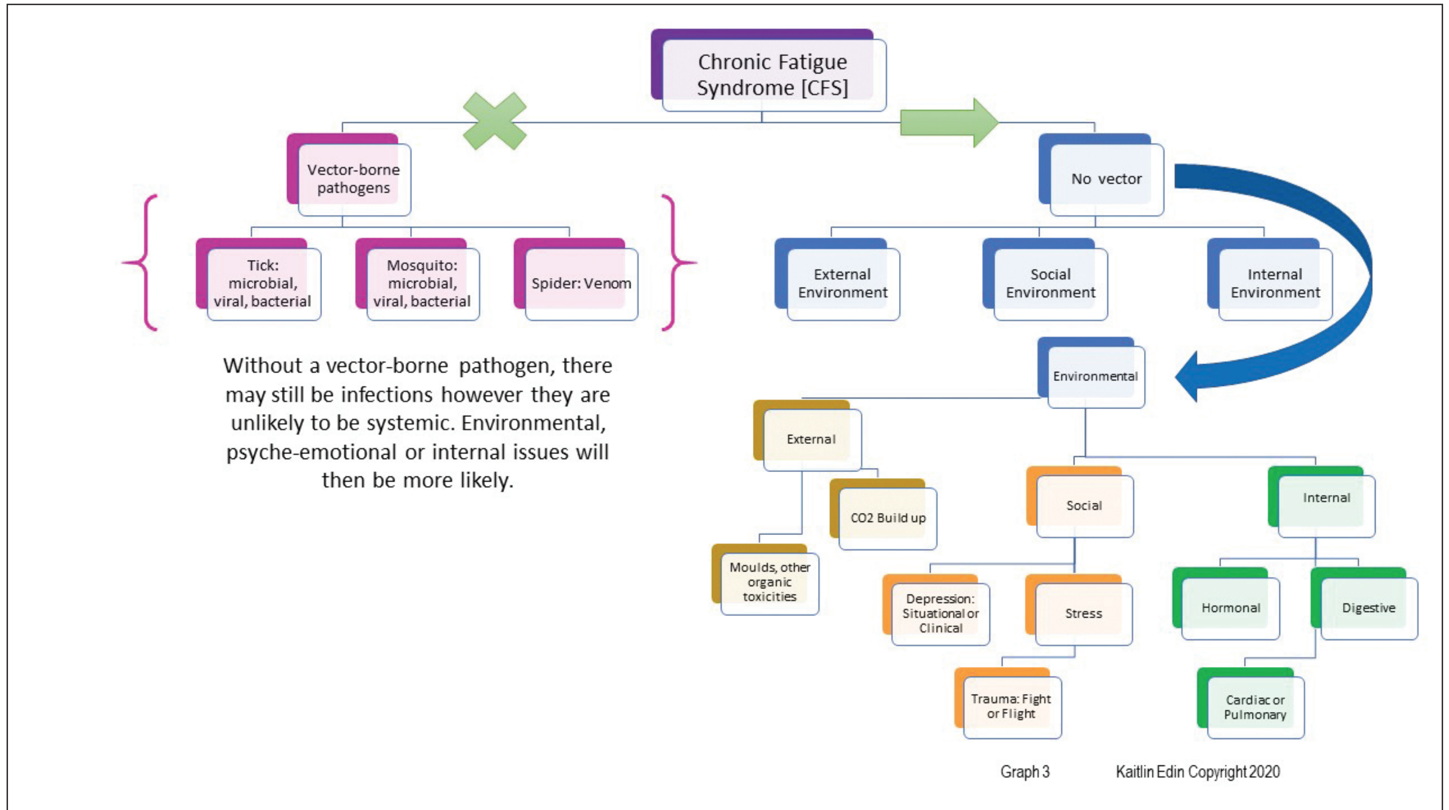
If there is active heat in the system perhaps it's because it has been caught early or the person has a strong constitution and the wei qi is mounting a defence. It is important at this stage that the yang qi of the body is as protected and nurtured as possible.

Pathogens can in fact be in all of the yang levels simultaneously. Particularly if we accept that the Taiyang can represent the nerves and nervous system, Yangming expresses in the digestive system and Shaoyang syndromes can compromise the fascial layers and soft connective tissue.

Even with a vector, don't discount what else might be happening in the environment of the patient.

Figure 3: If there is no vector that the patient reports, *still consider that there may well be infectious agents*, although they are unlikely to be systemic unless the

Figure 3: Chronic Fatigue Syndrome without a Vector-borne Pathogen



person is extremely weak. Yang qi can be weakened by a number of factors, (including childbirth, traumatic or highly stressful experiences, overworking, surgery etc.) of course, once in a weakened state the likelihood of contracting opportunistic infections is heightened. Consider also that for some systemic viral or bacterial infections (such as Lyme or Lyme-like infections) there is a possibility that exposure is second hand, through relational or sexual partners and so may be less likely to be considered.

The steps in figure 3 can assist you in making a differential diagnosis if you feel that the symptom set is not really sitting within the ME/ CFS frame, but further consideration of the environment could be warranted with or without a vector. The external environment can include things like black mould, or even $C0_2$ build up in houses that are well sealed and insulated or the use of un-flued gas heaters in the winter. These symptoms might tend to fluctuate with the seasons. Other toxins might include exposure to cleaning solvents or materials, pesticides and herbicides, or heavy metals (from old paints etc.).

The social environment can be where much of our stress comes. Family of origin dynamics, relationships, employment or financial worries can be just as toxic in the burden of stress as any pathogen. Relationship factors can be fracture lines that exacerbate 'pathogenic factors' and bring up underlying dynamics such as depression or anxiety. Birth, childhood or personhood trauma can and may continue to be significant stressors in a patient's life. Under these conditions of profound or 'toxic' stress, even a mild cold for someone in this condition could be overwhelming.

The internal environment can include poor or inadequate diet, food additives or allergens, compromised immunity from other factors, any kind of illness and poor recovery, hormonal dysfunction due to stress, and/or uterine or ovarian disruptions medications or addictions, constitutional issues of the heart or lung. It is also important to remember that liver function in people with ME/ CFS is often impaired, so sometimes herbal or ingestive treatments have to be done very carefully and slowly. Because of an impaired immune function Candida is a common co-current infection and can impact on digestive function and permeability[2].

Social, emotional or internal organ weakness can create fertile ground for the MS/ CFS symptom constellation to appear. How often have we seen someone in the clinic who feels like everything has 'gone wrong' all at once, or has had one thing after another such that all their internal and external resources are depleted? This is a state of significant vulnerability to opportunistic or latent infections.

Figure 4: The full diagram here gives a quick overview of how we can map the symptoms and get a handle

on the complex factors inherent in this syndrome. How we then treat is up to our own understanding and preferred diagnostic focus, patient preference and the realities of the present moment within treatment sessions.

Treatment Strategies

Treatment strategies for ME/ CFS as part of an Eastern medicine paradigm can include insertive acupuncture treatments: Dr Tan's Balance method techniques, particularly his advanced spiral balances for multi-system conditions are extremely helpful[17].

The Meridian Conversion and Seasonal balances which are also part of the advanced Si Yuan system can affect a number of meridian systems with very few pins, so this is an elegant and powerful way of working at several levels and keeping the pins to a minimum[17].

Susan Robideaux's scalp and abdominal acupuncture treatments[18] in combination also work well if your patient is more robust or there are significant cognitive or emotional components in the picture.

Non-insertive treatments like Dr Manaka cord treatment protocols[19] or treatments from within Japanese meridian therapy traditions can be helpful for those particularly weak patients. These treatments will usually involve the use of ion pumping cord treatments as well as needle head moxa at the back shu points which can be an important way of supporting the wei and yang qi of the body.

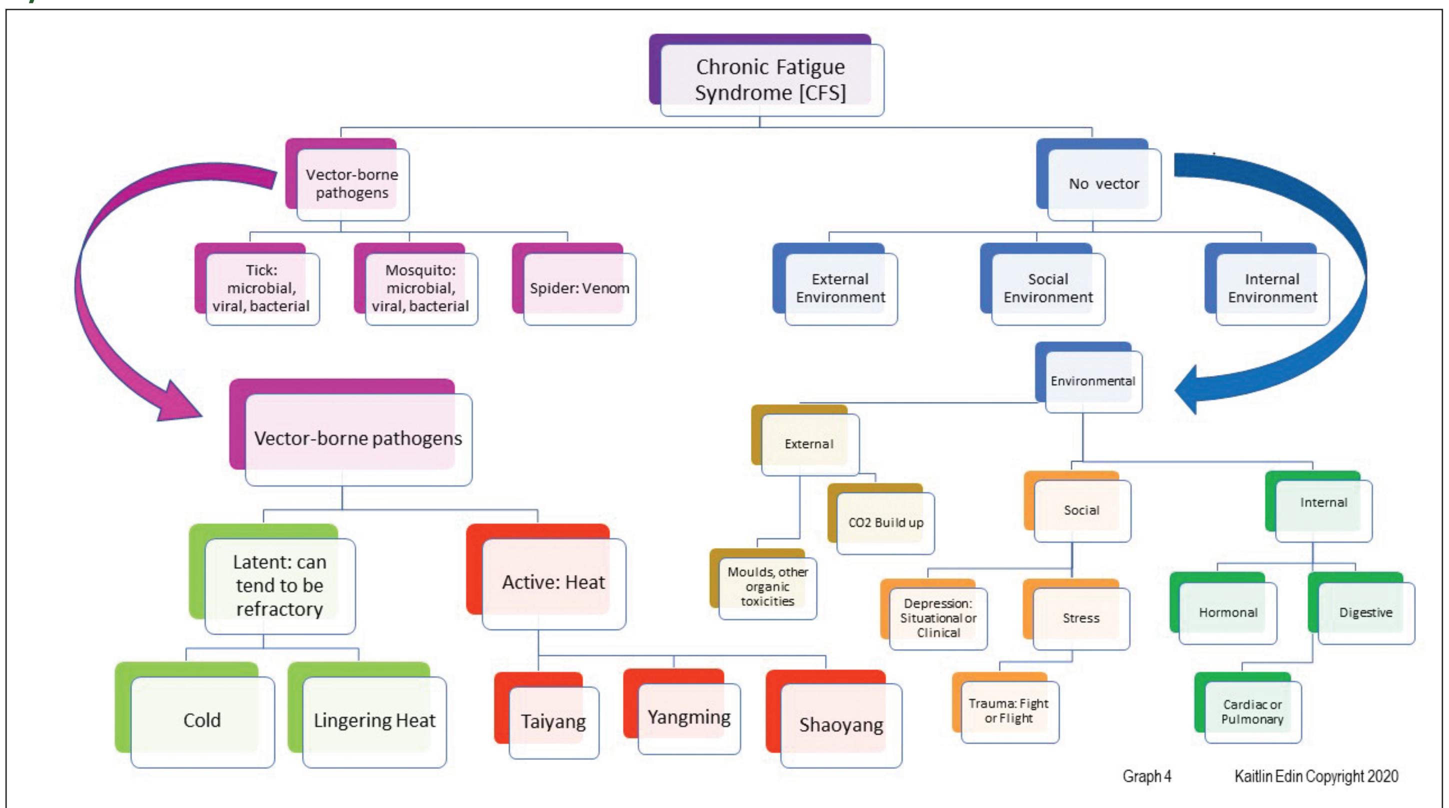
Cord treatments will often use the Eight Extraordinary Meridian connections, but as the cords are thought to move wei qi (more so than yuan qi) these treatments can be great for structural issues, including orthostatic intolerance. Needling in these treatments is often very shallow or kept to a minimum with taped silver spike points used instead.

Non-retaining needling techniques along the spine can also be supportive of the yang qi if the patient is not robust[4]. Meridan Therapy silver needle or teishin techniques are also of great benefit to support the wei qi and mood of the ME/ CFS patient.

Direct moxa treatments can be particularly rejuvenating for those patients with latency or cold type presentations. If moxa is used on its own as a therapy (with a combination of chinetsukyu, okyu and tiger or elephant warmer) it will assist consolidation of the yang qi and support the nervous system. Sometimes patients are too weak for inserted pins, so this is a wonderfully relaxing and supportive treatment strategy.

The indirect forms of moxa (such as the platform or ibuki moxa, as well as moxa sticks) can be good for home use, especially getting the patient or a support person to moxa St36 and GV20.

Figure 4: Quick Guide to Map Chronic Fatigue Syndrome



If your patient is strong enough and can manage guasha (often the thin Liver Blood types love this, the Spleen damp people less so) surprisingly this is an excellent way of releasing the waste and toxins that get sequestered into the connective tissue, and the Shaoyang.

A good way to support lymphatic drainage after guasha, especially if there is some congestion or swelling in the lymph is with the application of essential oils (in dilution). The ones especially good for lymphatic congestion include Bay Laurel, Eucalyptus, Fennel and Grapefruit[15]. Castor Oil can be a good carrier oil for removing toxins and resolving phlegm and damp.

Castor Oil packs as a home recommendation can be a good way to engage the patient in their healing and support the practitioner led treatments. Another great way to assist lymphatic decongestion is with dry brushing, particularly around the creases of the body[20].

Holistic Aromatherapy from within a Chinese Medicine diagnostic model and application using the Eight Extraordinary Vessels can be a beautifully calming and supportive treatment option, very good if there are issues for the patient around their blueprint or curriculum as Yuen (2018) terms it[15]. The challenges of this syndrome can go very deep for people.

Blends of oils for topical application, or even single oils in diffusers can work very well. They work effectively at a number of levels of the human energy system, are generally well tolerated and don't require much effort from a generally already overwhelmed patient.

(For more on the application of oils within a Chinese Medicine framework see Jeffrey Yuen (2018)[15] and an interesting book Essential Oil Analogues of Traditional Chinese Medicine Herbal Formulas by Aldrich & Bornemann (2013))[21].

If we fully embrace the energetics of the Eastern medical approach, we maintain our vibrancy as practitioners as well as the opportunity to perceive differently. Before we were herbalists or acupuncturists, we were translators. We spent years translating the terms of the dominant (Western) medical language and perspectives into a different medical and philosophical engine. Often Chinese Medicine is applied like a filter, put on over the top of our Western medical knowledge and understanding. This will take us only so far. If we understand the dynamics of the physical and energy body from within the Eastern medical paradigm, account for the individual constitution, and consider the many ways and approaches we can use to treat, it doesn't really matter whether we call it CFS, SEID, or a Lingering Pathogen. We will always have something to offer to our patients.

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