

Quest

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Clinical and Biochemical Characteristics Relating to Dysfunction of RNase L Pathway Differentiate ME/CFS from Major Depression and Healthy Controls

(Summary of Research Study: Suhadolnik RJ, Peterson DL, Reichenbach BS, et al. Clinical and Biochemical Characteristics Differentiating Chronic Fatigue Syndrome from Major Depression and Healthy Control Populations: Relation to Dysfunction of RNase L Pathway. Journal of Chronic Fatigue Syndrome 12(1):5-35, 2004.)

By Marjorie van de Sande, B. Ed, Grad. Dip. Ed.

This original research study by Suhadolnik et al. examined the relationship between clinical and functional characteristics, immune abnormalities, including the status of the RNase L pathway, in ME/CFS compared to healthy controls and depressed populations.

ME/CFS has shown patterns of immune system dysfunction. Increased immune system activation is evidenced by increased T lymphocyte activation and circulating cytokines. Poor cellular function is evidenced by low natural killer (NK) cell cytotoxicity (ability to destroy targeted cells such as pathogens) and impaired T lymphocyte response to mitogens.

The ME/CFS (66) group showed marked functional impairment in clinical, functional and biochemical

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abnormalities in comparison to the healthy control group (62) and the depressed group (51). The ME/CFS group demonstrated decreased cognitive performance, and significantly higher 37/80 kDa RNase L ratio compared to the two control groups. (Previous studies by Suhadolnik, De Meirleir, and others have demonstrated that the RNase L molecule, which normally weighs 80 kDa is being cleaved and many of these molecules weigh 37 kDa in ME/CFS patients.) The ME/CFS group also had low NK cell cytotoxicity compared to the healthy controls. The correlation between the abnormalities in the RNase L pathway and impaired NK cell function suggests that they may be part of the same disease mechanism. These findings support the cytokine/immune activation model of ME/CFS patients.

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Comparing the Canadian Clinical Definition and the Fukuda Criteria For Chronic Fatigue Syndrome

By Dr. Leonard Jason

(Dr. Jason published the results of his comparison study between the Canadian Clinical Definition and the Fukuda [CDC] criteria in Jason LA, Torres-Harding SR, Jurgens A, Helgerson J. "Comparing the Fukuda et al. Criteria and the Canadian Case Definition for chronic Fatigue Syndrome". Journal of Chronic Fatigue Syndrome 12(1):37-52, 2004.)

None of the current CFS case definitions have been empirically derived or prospectively contrasted with one another. Studies examining sources of diagnostic unreliability have shown that subject, occasion, and information variance account for only a small portion of diagnostic reliability. However, criterion variance, differences in the formal inclusion and exclusion criteria used by clinicians to classify patients' data into diagnostic categories, accounts for the largest proportion of diagnostic unreliability. Case definitions would be improved if more attention was devoted to developing operationally explicit, objective criteria and standardized interviews.

The selection of diagnostic signs and symptoms has

major implications for which individuals are diagnosed with CFS and how seriously the illness is viewed by health care providers, disability insurers and rehabilitation planners, and patients and their families and friends. Diagnostic criteria also have implications for whether research based on varying definitions can be synthesized. Our investigation examined differences between CFS as defined by Fukuda et al. (1994) and a set of criteria that has been proposed for a clinical Canadian Case definition. Dependent measures included: work status, psychiatric co-morbidity, symptoms, and functional impairment. People meeting the Fukuda et al. and Canadian criteria were compared with people who had a chronically fatiguing illness explained by a psychiatric condition. The Canadian criteria group, in contrast to the Fukuda criteria group, had more variables that significantly differentiated them from the psychiatric comparison group.

The findings suggest that both the Canadian and Fukuda et al. case definitions select individuals who are significantly different from psychiatric controls with chronic fatigue, with the Canadian criteria selecting cases with less psychiatric co-morbidity, more physical functional impairment, and more fatigue/weakness, neuropsychiatric, and neurological symptoms. The overall findings suggest that the Canadian clinical criteria appear to select a more symptomatic group of individuals than the CFS criteria, and these individuals do demonstrate less current and lifetime psychiatric impairment than those selected according to the CFS criteria. In contrast, the CFS group was not significantly different from the Chronic fatigue-psychiatric group in psychiatric impairment. Predictably, the Chronic fatigue-psychiatric group evidenced the highest frequency of current and lifetime psychiatric disorders.

Overall, there were 17 significant symptom differences between the Canadian and Chronic fatigue-psychiatric group, but only 7 significant symptom differences between the CFS and Chronic fatigue-psychiatric group. Findings suggest that the Canadian criteria select a group of patients with more symptoms, and the Canadian criteria identify a group with higher levels of physical functional impairment and less psychiatric co-morbidity. Findings from the present study indicate that the

Canadian criteria does capture many of these cardiopulmonary and neurological abnormalities, which are not currently assessed by the current CFS case definition (Fukuda et al., 1994). However, it is worth noting that when the Fukuda et al. (1994) CFS case definition was conceived, the research had not yet been done investigating these abnormalities. In combination with symptom patterns, it is possible to conclude that the Canadian group does select individuals with greater impairment, particularly given the physical composite score, fatigue/weakness, neurological and neuropsychiatric symptoms, as these symptoms can interfere with daily living and occupational performance. Results from this present investigation highlight the importance of contrasting different diagnostic criteria in order to gain a greater understanding of the syndrome now known as CFS. The findings do suggest that the Canadian criteria point to the potential utility in designating post-exertion malaise and fatigue, sleep dysfunction, pain, clinical neurocognitive, and clinical autonomic/neuroimmunoendocrine symptoms as major criteria for future attempts to define this syndrome.

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Physiological Mechanisms Discriminated Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS) from Depression and Healthy Controls

By Marjorie van de Sande, B. Ed., Grad. Dip. Ed.

A recent study(1) by Pazderka-Robinson, Morrison, and Flor-Henry indicates that both skin conductance levels and skin temperature can distinguish ME/CFS patients from those suffering with depression and healthy controls. This study adds to the growing body of evidence that demonstrates that ME/CFS has distinct neurobiological profiles.

Fatigue is a symptom of depression and some patients with ME/CFS suffer from depression, but there is only a partial overlap of symptoms and they may be qualitatively different. The research team (1) believes that this is the first electrodermal

activity (EDA) study of ME/CFS and depressed patients.

Study Subjects

The study included 43 ME/CFS patients, 25 depressed patients, and 44 healthy controls, all being right-handed females. Some ME/CFS patients had depressive symptoms sometimes in their past history but none were depressed at the time of testing. Non-responders were excluded to give the group participants as 36, 19, and 33 respectively. Variants of age were insignificant.

Experimental Conditions

“Subjects were seated in a padded armchair in a dimly lit, sound-attenuated, electrically shielded chamber, maintained at a temperature between 22 and 24° C. They were told that the study was concerned with the measurement of nervous system activity to tone and light stimuli, and were asked to rest comfortably with their eyes open. Recording equipment and experimenter were located outside the chamber.

Individuals were presented with an orienting task, in which 15 repetition (tone or light) trials were followed by a cross-modal change trial, and then the original repetition modality stimulus was presented on the last trial.”

Subjects had electrodes attached to the pads of their fingers and were exposed to a series of auditory tone stimuli (beeps) and a series of light stimuli (flashing lights from an overhead lamp). Bilateral electrodes were placed on the third and fourth fingers of each hand to record electrodermal activity and the temperature of the skin was taken with a distal phalange of the fifth finger of both hands.

As there were no significant differences between the responses to auditory and visual stimuli, they were reported collectively. Similarly, there were no significant differences between the responses of the right and left hand of an individual so these results were not differentiated. Responses to the final group of stimuli were eliminated due to the

relatively higher number of non-response by the fourth trial.

Results

Skin conductivity is the ability of the skin to conduct electric current. Three skin conductivity physiological responses were measured: at rest (pre-stimulus tonic level), intensity of the reaction to the electrical current (amplitude of first response to electrical current in the skin), and the habituation to the initial response (the difference in amplitude between the first and third trial).

There were significant differences between the ME/CFS patients and the other groups. The skin's ability to conduct electrical current in response to visual and auditory stimuli was significantly lower in ME/CFS patients in the pre-stimulus test as compared with healthy controls and depressed patients.

The mean responses to the first stimulus did not differ significantly between the three groups but the depressed group showed the lowest response amplitude to the first stimuli and the greatest rate of habituation over the three stimuli. That is, they had the least increase of electrical conductivity in response to the first series of electrical stimuli and had the highest degree of adaptability over the three series of stimuli.

Skin Temperature: The temperature of the skin was taken with a distal phalange of the fifth finger of both hands prior to the skin conductance tests. The temperature of the skin of the fingers was significantly higher in people with ME/CFS than in healthy controls of those with depression. These results may seem surprising, since the body temperature of ME/CFS patients is often below normal. However, the skin temperature and the body core temperature are regulated by different mechanisms of the body and suggest that ME/CFS subjects are sensitive to discrepancy between core temperature and temperature of the extremities. This may be due to peripheral vasodilatation.

There was no significant difference in skin temperature between healthy controls and depressed patients.

Conclusion: The combination of a lower ability of the skin to conduct electrical current and a higher skin temperature in prestimulus conditions indicate a “down-regulation of autonomic sympathetic tone, as the sympathetic system is responsible for vasoconstriction in the periphery”.(1) These findings are generally consistent with reports of decreased levels of cortisol in ME/CFS patients(2,3), which is the opposite of increased cortisol levels found in somatization syndrome(4). The data of this study “is concordant with the review of HPA reactivity in CFS generally showing decreased basal levels and average or blunted responses in provocative testing.”(5) They may also reflect altered cardiovascular activity in ME/CFS patients. The authors suggest that the *lowered* sensitivity to internal warning indicators may contribute to the overexertion and exhaustion found in ME/CFS. Put simply, the body is not adequately sensitive to exposure to physical or mental stressors or exertion, so it does not adjust or reset its baseline for reactivity resulting in overexertion and exhaustion. The lack of internal adaptability to stressors such as pathogens, toxins, and daily stressors results in inadequate rest periods and may help explain why it is so difficult for many ME/CFS patients to pace themselves adequately and why they frequently “crash”.

The markedly lower prestimulus tonic skin conductance levels and concurrent elevated skin temperature levels found in ME/CFS patients in this study “add to the growing body of evidence demonstrating that ME/CFS and depression have distinct neurobiological profiles, consistent with unique aetiologies.”(1)

Other studies indicate ME/CFS patients have measurable functional impairment, biochemical abnormalities and other physiological differences, which distinguish them from depressed patients including altered sympathetic modulation(6), reduced neuroendocrine HPA function(5,7,8,9), increased 5-HT neurotransmission(2), orthostatic intolerance(10) reduced specific cognitive performance such as decreased processing speed, working memory, and information learning(11,12). Altered immunological profiles(13) including significantly higher 37/80 kDa RNase L ratio(14, 15) and lower NK (natural killer) cell cytotoxicity(15), changes in the cerebral white

matter suggesting demyelination(16) are also exhibited in some ME/CFS patients. The numerous abnormal responses to exercise in ME/CFS patients are markedly different than in depressed patients(17).

ME/CFS is classified as a neurological illness in the World Health Organization's International Classification of Diseases. As with any chronic illness, particularly a poorly understood one, reactive depression is not uncommon. Some ME/CFS patients do not exhibit any psychiatric disorder(18). The increasing evidence distinguishing between the two illnesses suggests that diagnosis of depression is not only inappropriate, but is distressing to ME/CFS patients(19), and may undermine treatment efforts(10).

It should be noted that in Dr. Leonard Jason's comparison study(21) of the Canadian Clinical Definition and the Fukuda criteria, the Canadian definition, which included more physiological symptoms and signs, was able to statistically significantly differentiate ME/CFS patients from the psychiatric comparison group. The Canadian criteria select patients with more physical functional impairment, more fatigue/weakness, more neurocognitive and neurological symptoms, and less psychiatric symptoms.

If the results of the study by Pazderka-Robinson, et al(1) are duplicated by other researchers, the skin temperature of the fingers and skin conductivity could be the first step in developing these simple objective tests for ME/CFS.

(This article was kindly reviewed by Dr. Bruce Carruthers.)

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Gulf War Illness Update

House of Commons, Ottawa, 17 February 2005
MP Betty Hinton, Veterans Affairs Critic for the Official Opposition

Mr. Speaker,

“Monday, February 28, will mark the 14th Anniversary of the liberation of Kuwait. Some 4500 members of Canada's Armed Forces served in the Gulf War. Many came home with debilitating medical conditions and were subsequently released from the Armed Forces.

Little has been done in the last fourteen years to address these medical conditions, other than slap a label of post traumatic stress syndrome on them and cut them adrift.

Mr. Speaker, you often hear the word family used in connection with the Canada's military and I can tell you this is no way to treat a family member. Not only have they been treated badly by their own country they are not even allowed to accept a medal from Kuwait in appreciation for their service. This is just not right.

I would ask this government, in this Year of the Veteran, to act in the best interest of these Veterans, do not wait the traditional 40 or 50 years and then give them a compensation package. Make things right for these Veterans now.”

[Ed. Note: On Monday, February 28, 2005 Kuwaiti Ambassador Musaed Rashed Al Haroon held a reception at his Embassy in Ottawa to honour the Canadian veterans of the Gulf War. Mr. Al Haroon beat the Canadian government in commemorating the veterans, who have been waiting 14 years for a ceremony hosted by the federal government.]

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Beat the Snail-Mail - Become an Online Member!

If you are a member and would like to download our newsletters from our website <http://www.mefmaction.net> as soon as it is ready rather than waiting for it to be printed and mailed to you by snail-mail, email Marjorie van de Sande at mvandes@shaw.ca . When Marj receives your request, she will program you into the secure **Members Only** area and email you with instructions on how to register. Please allow two or three weeks for her response. This will also save us administration costs. Online Members will also be able to access our "**Quest Library**", which contains past newsletters, and selected Research Abstracts that are located in the Members Only area.

The focus of our new website is to make it as user-friendly as possible. If you have already saved our website in your "**Favorites**", delete it and then save it again. Instead of the 'e' that usually precedes a website, you will find our logo, which will make it easy to locate.

**LOEWE V. GUARANTEE INSURANCE –
Intervenor Status Update (also see Quest
#66)**

**By Hugh R. Scher, Barrister & Solicitor for the
National ME/FM Action Network**

This matter was heard by the Ontario Court of Appeal on Wednesday, December 1, 2004.

The Court seemed genuinely interested in the issues raised by this appeal. Many questions were asked of counsel for the appellant, the respondent and I regarding the appropriate standard that ought to apply in order to enable a claim to proceed against a DAC (Designated Assessment Centre).

The Court seemed to be grappling with whether or not a standard of mere negligence would be sufficient to justify a claim, whether or not negligence, plus an additional element of bad faith would be required in order to justify a claim, or whether a claim could proceed in bad faith in circumstances such as those found in the case of malfeasance of a public official. With respect to the latter standard, the court seemed favourably inclined to consider a claim in circumstances where a DAC engages in bad faith conduct contrary to its duties and obligations under the legislation and guidelines governing DAC assessments.

It appeared that the court was particularly concerned about the prospect raised by the respondent that DAC assessors could be completely immune from legal action in cases of malicious, fraudulent, dishonest, bad faith conduct.

At this time, we are awaiting the decision of the Ontario Court of Appeal and will report on same at that time.

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IME/FAE REGISTRY SUBMISSIONS

The **National ME/FM Action Network** continues to urge those who have attended an **Independent Medical Examination (IME)**, **Functional Abilities Evaluation (FAE)** or any other form of assessment at the request of an insurance company, Canada Pension Plan (CPP) or Workplace Safety & Insurance Board (WSIB) to fill out our 7-question, confidential, **Independent Medical Examination Registry Submission Form** so that the names of the doctors and healthcare professionals who evaluated you can be put on record.

Patients, doctors, lawyers, advocates, support groups wishing to receive a copy or copies of the Form, or to inquire about specific IME doctors, please contact: **National ME/FM Action Network** – Or download the Form from our website at **www.mefmaction.net/medexac.html**.

**Canadian Underwriter - Liberals offer up
new DAC replacement scheme in Ontario
12/6/2004**

According to documents from the Financial Services Commission of Ontario (FSCO) obtained by Canadian Underwriter, a new system to replace Ontario's "Designated Assessment Centers" (DACs) has been established.

The new "post-DAC" system would allow claimants to receive assessments within the Statutory Accident Benefit Schedule (SABS) from their health care provider, and allow insurers to request their own assessment if the initial assessment is in question. However, the DAC stage is eliminated and a disputed SABS claim will go directly to FSCO's dispute resolution process or to the courts following mediation. The goal is to eliminate DACs, which were found to be a costly and duplicative service by the new Ontario Liberal government. The first stab at reform, the "expert assessor network" was not well received by stakeholders, including insurers, sending the government back to the drawing table.

The new system, which will require amendments to the SABS regulations, will create a new category of examinations in addition to existing "section 24"

assessments. The "pre-claim examination" can be requested by the insurer and within five days following that examination a report would be sent to insurer, insured and the insured's health practitioner.

Other changes include the removal of attendant care benefits from the SABS, with approval for such benefits to rest with the superintendent of FSCO; insurers being allowed to negotiate assessment fees directly with individual health care providers; the potential to avoid multiple assessments by combining them into one comprehensive examination; set timelines for the completion of assessments and notification to parties; the elimination of the DAC committee with no replacement.

New regulations to amend the Insurance Act also set out a clear list of what will be considered "unfair or deceptive practices", including an insurer requesting examinations which are not reasonably required, or a service provider accepting or paying referral fees. It is expected the full proposal will be released on the FSCO website.

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BREAKING NEWS!!

The Myalgic Encephalomyelitis Association of Ontario is pleased to announce that

ME/CFS has now been given 'Official Ontario Government' recognition!

This means that no one in Ontario who suffers from ME/CFS can ever again be told by a doctor that ME/CFS does not exist. If they do, tell them to look up **Diagnostic Code 795**. 'Chronic Fatigue Syndrome' has been given the

OHIP Diagnostic Code 795 by the Ontario Medical Association as a Neurological Illness!

Ideally, we wanted the Diagnostic Code to read: 'Myalgic Encephalomyelitis/Chronic Fatigue Syndrome, but we had to take what the Ontario Medical Association approved. The most important fact is that 'Chronic Fatigue Syndrome' is now officially recognized as a Neurological Illness in the Province of Ontario, Canada. Perhaps the other

Provincial Ministries of Health in Canada will follow?

It has taken many years to get to this point of lobbying, meetings, etc. With the publication of the Canadian Definition, which was initiated by the **National ME/FM Action Network**, this made this possible. Over the last several years, **The Myalgic Encephalomyelitis Association of Ontario** has been in meetings with the Ontario Ministry of Health to lobby for a Diagnostic Code and we are so pleased that we now finally have one. **Dr. Alison Bested** did a fantastic presentation to the Ontario Medical Association. **What does it mean to have a (CFS) code"? It means that:**

1. NO physician can ever say again that our illness does not exist;
2. All physicians in Ontario will receive a notice from **OHIP** of our new **CFS Diagnostic Code 795** as a **Neurological Illness**;
3. The fact that the Ontario Medical Association gave CFS a Diagnostic Code as a Neurological Illness will cause concern to Insurance companies;
4. It will help individuals applying for Ontario Disability Support Program and the Canada Pension Disability Plan;
5. It now makes it possible to collect Statistics in Ontario; and
6. It will hopefully give incentive to the other provinces to follow.

NOTE: The CFS Diagnostic Code is given to someone who is being diagnosed with CFS for the first time. The code is not a time-based fee code. Follow up appointments for any illness (heart disease, MS, CFS, etc. at the present time is usually billed as Supportive Therapy if you take more time than a normal appointment.

[Ed. Note: Congratulations and Thanks for making this happen to Dr. Alison Bested and The Myalgic Encephalomyelitis Association of Ontario who can be reached at 2336 Bloor Street West, P.O. Box 84522, Toronto, ON M6S 4Z7 Tel. (416) 222-8820 or 1-877-532-6682 Web: www.meao-cfs.on.ca]

A Letter from a Fan

"The recent influx of posts regarding the lack of trust in the most prominent ME advocacy groups and the inaction on their part has pushed me to write this email. There are other groups out there trying to help at the grassroots level. [However] we don't hear enough about them because they don't get the publicity.

*One group that is trying to make a difference is the **National ME/FM Action Network in Canada**. I see the Canadian Consensus Diagnostic Criteria document mentioned frequently on US and UK posts as a viable alternative to the current criteria. Why not support the very group that made this possible in the first place?*

Recently they have been granted intervenor status in a court case that will determine the right of ME/FM patients to sue a negligent IME (Independent Medical Exam) doctor. Although it applies to Canadian cases at this time, the outcome could impact worldwide eventually. They are desperately in need of funds for legal fees.

Become a member and help a group that is doing its part to gain recognition and support for those of us with ME/CFS. They wholeheartedly accept members from other countries. Check out their website at <http://www.mefmaction.net/> There is a quarterly newsletter chock full of information.

When you see how much they've accomplished with very few people and very little money, imagine the possibilities if they had more worldwide support.

Mary Anne, Richmond BC Canada"

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National Lawyers' Roster – Addition

Sandra G. Drozd, Law Firm of Lerner LL.P.
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RESOURCES

The FMS Consensus Document has been published as a soft cover book. Price **US\$24.95**

"The Fibromyalgia Syndrome: A Clinical Case Definition for Practitioners".

Haworth Press, 2004.

ISBN: 0-7890-2574-4 Online orders:
<http://www.haworthpress.com/store/product.asp?sku=5342>

The ME/CFS Consensus Document

"Myalgic Encephalomyelitis/Chronic Fatigue Syndrome: Clinical Working Case Definition, Diagnostic and Treatment Protocols" Price: **US\$14.95 in**

(Journal of Chronic Fatigue Syndrome, Vol. 11, No. 1, 2003) Haworth Press 2003/2004

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How to STOP Being Vampire Bait: Your Personal Stress Annihilation Program

By: Dr. Richard L. Bruno

Dr. Richard Bruno, the world's expert on STRESS and Post-Polio Sequelae, teaches you not merely to manage but actually to annihilate STRESS with his new e-book, **How to STOP Being Vampire Bait: Your Personal Stress Annihilation Program**.

Through clear explanations, common sense examples and simple homework assignments, this self-taught, four-week program will:

* Explain what STRESS really is and why it's trying to KILL you.

- * Measure just how "Type A" and STRESSED out you are.
- * Explain why STRESS is a leading cause of PPS, chronic fatigue and chronic pain.
- * Help you to identify your Body's and Brain's STRESS Signs.
- * Help you to discover your personal STRESS Triggers and STRESS Patterns.
- * Help you to uncover the STRESS-Producing Vampires in your life.
- * Introduce you to Buddhism, the 2,500 year old philosophy that was the first "12 Step" program to Annihilate STRESS.
- * Present "The Ten Commandments" of STRESS Annihilation.
- * Explain how "divorcing" your relatives can be the key to annihilating STRESS.

How to STOP Being Vampire Bait: Your Personal Stress Annihilation Program was specially written for anyone with a disability or chronic illness – including ME/CFS, fibromyalgia & chronic pain – to help you to annihilate STRESS, feel better and maybe even to live longer.

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The following resources can be ordered from the National ME/FM Action Network. Prices include Shipping and Handling. Cheques should be made payable to the National ME/FM Action Network or you may pay by VISA or MasterCard

TEACH-ME - Sourcebook for Teachers, Cost \$22.00: An educational resource book full of information and teaching strategies for teachers and parents of children and youth who have ME/CFS and/or FMS –Discount on bulk orders.

We are pleased to announce that the **Second Edition** of **TEACH-ME** is almost ready for printing.

Please also see our youth and parents’ pages on our website at: **www.mefmaction.net**

By popular request, the **National ME/FM Action Network** has published an easy to read book consisting of a **collection** of important articles which have appeared in our ‘**QUEST**’ newsletters over the years. For easy reference, these articles have been grouped into sections according to their focus of medical, legal and advocacy.

QUEST COLLECTION I BOOK – FIVE YEARS (1993 TO 1998) Cost: \$20.00:

QUEST COLLECTION II: (1999 to 2003): Cost: \$38.00.

NEW: NOW AVAILABLE FOR PURCHASE: The Canada Pension Plan Disability Benefits Guidelines: Cost \$7.00. New up-dated guidelines have been designed to assist those disabled by ME/CFS and/or FMS applying for Canada Pension Plan Disability Benefits. Understand the criteria, important items to include and how to proceed through the various steps of the process.

Legal Disability Manual: Extensive revisions, updating, and new articles have been added to the new Legal Disability Manual. Sections include: FMS and ME/CFS Overview; The Medical Report and Expert Witnesses; Independent Medical Examinations; CPP Disability Benefits, Disability Insurance and Other Legal Articles; Case Law; Psychological Factors, Tests, and Treatments; and

Research Abstracts. Many of the articles have been written specifically for the **National ME/FM Action Network** by lawyers and doctors. Our new Canada Pension Plan Disability Benefits Guidelines are also included in the Legal Disability Manual. This manual is a must for those in litigation.
Cost: \$60.00

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Psssssst NEXT ISSUE – SPRING 2005

THE GOOSE STORY

Next Fall, when you see Geese heading South for the Winter....flying along in a "V" formation... you might consider what Science has discovered:

As each bird flaps its Wings, it creates an Uplift for the bird immediately Following.

By flying in "V" formation the whole flock adds at least 71% greater flying range, than if each bird flew on its own.

**PEOPLE WHO SHARE A COMMON DIRECTION
AND SENSE OF COMMUNITY
CAN GET WHERE THEY ARE GOING MORE QUICKLY AND EASILY
BECAUSE
THEY ARE TRAVELLING ON THE THRUST OF ONE ANOTHER.**

When a goose falls out of Formation it suddenly feels the Drag and Resistance of having to go it alone....and quickly gets back into Formation to take Advantage of the lifting power of the bird in front.

**IF WE HAVE AS MUCH SENSE AS A GOOSE
WE WILL STAY IN FORMATION WITH THOSE
WHO ARE HEADED THE SAME WAY WE ARE.**

When the Head Goose gets tired it rotates back in the Wing...and another goose flies Point.

**IT IS SENSIBLE TO TAKE TURNS DOING DEMANDING JOBS
WITH PEOPLE OR WITH GEESE FLYING SOUTH**

Geese honk from behind to Encourage those up Front to keep up their Speed.

WHAT DO WE SAY WHEN WE HONK FROM BEHIND?

Finally....and this is important, when a goose gets sick, or is wounded by Gunshots, and falls out of Formation, two other Geese fall out with that goose and follow it down to lend Help and Protection.

They stay with the Fallen Goose until it is able to fly or until it Dies; and only then do they launch out on their own or with another Formation to catch up with their Group.

**IF WE HAVE THE SENSE OF A GOOSE
WE WILL STAND BY EACH OTHER LIKE THAT.**

Author unknown.

