



# Solve M.E.

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## Public Comments: The Systematic Review Report for Diagnosis and Treatment of Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS)

Dear Centers for Disease Control,

Please consider this letter formal public comments and recommendations submitted on behalf of the Solve ME/CFS Initiative (Solve M.E.). It is vital that a comprehensive review regarding the field of myalgic encephalomyelitis/ chronic fatigue syndrome, ME/CFS, acknowledge that people with ME/CFS have unique medical needs and have historically been excluded from meaningful participation in the creation of critical documents like this one. Upon reviewing the content of this draft evidence review and the process that created it, Solve M.E. feels that the unique medical needs and meaningful participation of the patient and stakeholder population were not included. In its current form, the review fails to meet the stated goals of the CDC, fails to address the intent of Congress as articulated to the agency, and most importantly, fails to capture the collected knowledge and guidance of the field, its sole purpose.

For these reasons and others outlined below, Solve M.E. strongly **recommends against the adoption of this review in any format** and encourages the CDC to refocus its priorities in developing the outcomes aligning with the guidance provided by Congress.

After more than a year and a half into the COVID-19 pandemic and the emergence of Post-acute COVID-19 syndrome (PASC), that in many cases is indistinguishable from ME/CFS, it is a matter of public-health urgency to address the ME/CFS case definition issues and clinical care crisis now.

### Executive Summary

Solve M.E. has analyzed the draft of "[Management of Myalgic Encephalomyelitis/Chronic Fatigue Syndrome \(ME/CFS\): An Updated Systemic Review](#)" (the review) primarily by looking at how the review

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addresses the stated goals of the CDC and expressed guidance of Congress. In 2018 Congress clearly expressed its expectations: “The Committee...encourages CDC to work with disease experts and patients to continue to better educate healthcare providers about the disease,” “address the continued medical stigma and misinformation,” and “partner with other HHS agencies, disease experts, and key medical societies.” We view the lack of patient and stakeholder participation and incorporation of medical stigma and misinformation as a critical deficiency in the process and outcome of this review. From this perspective, we find that the review did not follow the guidance and completely failed to address the desired goals of Congress.

Solve M.E. joins our many colleagues in strongly voicing our concerns about the development, process, content, and findings of this review. We agree with submitted comments criticizing the applicability of findings, ineffectiveness of the review, failure to adequately address harmful evidence, and failure to address bias. The review fails to move the field forward and provides no help to either the existing ME/CFS population or the future scientists of the field.

The review falls prey to the same bias and stigma that Congress instructed CDC to counter. And yet, we believe the CDC can still invest in this effort to meet its goals. Solve M.E. is committed to being a trusted partner in efforts to reassess the future of this project and create a plan to revise it to meet relevant needs and congressional intent. Together, we can create valuable guidance that “resolves the case definition issues” and “counters medical misinformation and stigma” just as Congress has repeatedly requested in report language from FY2018 and FY 2019.

We applaud the CDC’s work in [rapidly developing an interim guidance for Long COVID](#) that makes references to ME/CFS (and other related diseases and comorbidities). This is a critical public-health need as the number of people contracting COVID-19 continues to surge, and more people experience Long-COVID, that is often indistinguishable from ME/CFS. Many have noted that this interim Long COVID guidance was produced with fewer resources, far fewer significant published studies, and in a shorter period of time than the draft ME/CFS systemic review. By comparison, we find this ME/CFS review outdated, incomplete, and irrelevant to the current needs and gaps of the field.

### **Potential Links Between Post-COVID Conditions and ME/CFS**

Given the significant overlap and near-identical symptom presentation of ME/CFS and Long COVID, Solve M.E. strongly encourages the CDC to revisit this report and incorporate new information from post-COVID-19 cases of ME/CFS. This information is critically groundbreaking for the field and will undeniably improve the accuracy and usability of the review. This further strengthens our call for the CDC to continue building on this Review, improving the integration of stakeholder voices by using the recommendations we outlined above, and developing another draft report for public comment.

According to the CDC’s Congressional testimony, [up to 20% of COVID-19](#) patients are experiencing extended symptoms more than 30 days post-infection. These symptoms commonly include: extreme fatigue, post exertion malaise, significant reduced cognitive and physical capacity, muscular/skeletal pain, brain inflammation, orthostatic intolerance, and shortness of breath. Studies of patients infected with previous coronaviruses (SARS and MERS) also find similar results of a subset of patients who experience lasting post-viral symptoms consistent with ME/CFS. In fact, reports are already surfacing of COVID-19 survivors being diagnosed with ME/CFS. [Experts expect a significant increase of ME/CFS](#) cases in the next two years in the United States following the COVID-19 pandemic.

On June 14, 2021, CDC released “[Evaluating and Caring for Patients with Post-COVID Conditions: Interim Guidance](#),” which notes “some presentations [of post-COVID conditions] may share similarities with other



post-viral syndromes, such as myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS).” The CDC further notes symptom management approaches from ME/CFS that may be helpful to post-COVID conditions, including pacing for post-exertional malaise. It seems like a serious disconnect within the CDC that your systemic review teams are not investigating treatments that the CDC itself identifies as “helpful.” It’s very concerning that Long COVID patients can benefit from ME/CFS treatment recommendations and yet this systematic review finds a “low strength of evidence” for those same treatments.

Solve M.E. urgently calls for increased research investments regarding the post-viral and long-term impacts of COVID-19, especially in cases resulting in an ME/CFS diagnosis. We encourage CDC to take full advantage of the internal expertise within your ME/CFS team and fully integrate these experts into your Long COVID efforts. Solve M.E. further recommends that Long COVID studies incorporate ME/CFS comparison groups. Lastly, Solve M.E. recommends adopting the Common Data Elements for ME/CFS into Long COVID research and harmonizing data across studies so that data and findings can be utilized across multiple research disciplines and medical fields.

### **Congressional Intent**

In FY18 and again in FY19, Congress provided the CDC with committee report language stating key priorities and intention. While not identical, several key elements were repeated both years. In FY 18, the [Committee stated](#) (emphasis added):

*The Committee applauds CDC’s efforts to **collaborate with disease experts** in its multi-site study to **resolve the case definition issues** and urges CDC to complete that effort. The Committee encourages CDC to partner with other HHS agencies, disease experts, and key medical societies to implement a proactive dissemination plan **that counters medical misinformation and stigma** and addresses other key barriers to clinical care.*

In FY 19, [Congress again stated](#) (emphasis added):

*The Committee applauds CDC’s efforts to **collaborate with disease experts** in its multi-site study to **resolve the case definition issues** and urges CDC to complete that effort... and **encourages CDC to work with disease experts and patients to continue to better educate healthcare providers about the disease and its appropriate management**. However, the Committee is concerned that neither the website updates nor CDC’s current plans will address the **continued medical stigma and misinformation** about CFS and the critical lack of medical providers. **CDC is encouraged to partner with HHS agencies and other experts to address these issues** and find creative ways to bring additional clinicians into the field.*

This guidance was provided prior to the September 2018 announcement of this contract opportunity and Solve M.E. expected that these Congressional priorities would be incorporated into the report directive given to the experts conducting the review. However, based on the outcomes of this systematic review, it seems clear that these Congressional directives were not incorporated into the CDC’s instructions to Pacific Northwest Evidence-based Practice Center (EPC). This draft review fails to address the guidance of Congress in the following areas:

- **“collaborate with disease experts”**: Pacific Northwest EPC states that the report included the “input from the CDC and eight Key Informants,” which Solve M.E. considers inadequate for modern standards of meaningful patient engagement and collaboration.



- **“resolve the case definition issues”**: The draft evidence review absolutely does not resolve case definition issues. In fact, the review adds additional confusion, unravels current progress made towards resolving case definition issues, and actively adds additional confusion to these issues.
- **“counters medical misinformation and stigma”**: Please refer to the submitted comments of #MEAction pages 15 – 26 for a detailed description of the various failures of this evidence review to counter medical information and stigma.
- **“encourages CDC to work with disease experts and patients to continue to better educate healthcare providers about the disease...”**: Again, the eight key informants may have included patients, but we cannot confirm that since the information about the informants was never released. Additionally, these findings provided no helpful information to healthcare providers about the disease and provides no new information either. Especially considering other exceptional resources, such as the [U.S. ME/CFS Clinician Coalition Guidance on Diagnosis and Management](#) published earlier this year, the information in this systematic review is already outdated and irrelevant. This raises concerns that the CDC contractors are not monitoring significant events in the field and adjusting accordingly.
- **“CDC is encouraged to partner with HHS agencies and other experts to address these issues”**: Based on the published methods and process described in the draft review, it’s clear that other key agencies, particularly NIH, were missing from the process.

### **CDC Priorities, Process, and Stated Solicitation Goals**

On September 8, 2018 when the CDC announced solicitation number 75D301-18-Q-69445, the project title was initially [“Evidence-based treatment guidelines for ME/CFS.”](#) The announcement references an “existing systematic literature review” completed by the Pacific Northwest EPC. Within this announcement, the CDC describes the goal of this solicitation as (emphasis added):

*The CDC has a requirement for **updating ME/CFS treatment guidelines** with recent literature and supplementing the prior review and guidelines that were recommended by the HHS CFS Advisory Committee in June, 2017. In addition, **any peer-reviewed literature that could provide context to inform treatment recommendations for symptoms associated with ME/CFS warrants review and consideration.***

Solve M.E. was very disappointed to see this change to a reduced scope and limited goals. Especially when both Congress and the CDC had stated different goals so clearly:

- **“updating ME/CFS treatment guidelines”**: Given the title of the solicitation and this statement, Solve M.E. was anticipating treatment guidelines as a result of this project. Instead, the Pacific Northwest EPC delivers an additional systematic evidence review that differs little in content than the “existing systemic literature reviews” already published at the time of this solicitation. It is important to note that these previous reviews were also authored by Pacific Northwest EPC so the duplication of effort is distressing and promotes distrust in this contractor.
- **“any peer-reviewed literature that could provide context to inform treatment recommendations for symptoms associated with ME/CFS warrants review and consideration”**: Solve M.E. finds the inclusion criteria of the systematic evidence fundamentally flawed and in conflict with CDC’s stated purpose. In the Pacific Northwest EPC review, a wealth of knowledge and peer-reviewed papers were disregarded, including: patient-led research, non-English speaking researchers, papers regarding harms, alternative treatments, and studies



conducted outside of clinical settings (eg. in-home based settings), which specifically excludes most severe patients from the research.

Additionally, Solve M.E. is disappointed in the lack of accessibility and transparency in the process that was utilized to select Pacific Northwest EPC for this contract. The initial public solicitation was posted on **Saturday** September 8, 2018 with a response date of **Thursday** September 13, 2018 at 1pm ET. This provided only 3 ½ business days for interested parties to apply. These actions erode trust in the CDC and demonstrate clear favoritism for the handpicked Pacific Northwest EPC team.

In the past, the CDC has stated that an evidence review was necessary before any interim guidance would be possible. Yet, for Post-COVID Conditions that did not seem to be the case as interim guidance was published in June 2021 without a published systemic evidence review.

### **Patient, Provider and Stakeholder Inclusion**

Solve M.E. applauds this public comment process and encourages the CDC to utilize open forums like this in the future when developing critical guidance and disseminating key information. Given the historical harms inflicted upon the ME/CFS community, patient inclusion is absolutely critical in this community to foster trust, build consensus, and heal the harms of the past.

Unfortunately, the Pacific Northwest EPC failed to recognize and deliver in this area. The eight person “key informants” group was woefully inadequate to meet these needs and lacks transparency. Furthermore, the CDC’s 4-day solicitation and perceived favoritism towards the Pacific Northwest EPC deteriorated the community trust in this process. Solve M.E. encourages CDC to review the 2019 Request for Information ([NOT-NS-19-057](#)) conducted by the NIH and incorporate more public comment periods such as this one. We expect more transparency in the process and community participation earlier in the process of generating materials that impact the ME/CFS community.

Solve M.E. offers the following suggestions for mechanisms to improve patient inclusion in the process and rebuild community trust:

- CDC should make a statement reassuring the community that this report will not be adopted in its current form
- Restructure Northwestern’s role in this process
- Solicit additional bids for the next phases of this report, specifically instruct these future contractors to create Evidence-based and expert-based Treatment Guidelines
  - Ensure this solicitation is open long enough for stakeholders to participate
- Host a series of community listening sessions to determine next steps in this process
- Reopen the drafting process with a formalized mechanism (e.g. focus groups, working groups, etc.) for stakeholders to contribute
- Identify a mechanism for interagency contribution, especially NIH
- Repeat this public comment process for the next phases of the report
- Align internally with any treatment guidelines related to Long COVID.

Overall, Solve M.E. encourages CDC to continue this work in partnership with stakeholders and representatives of the ME/CFS community. The outcomes of the next iteration should prioritize “resolving the case definition issues” and “*better* educating healthcare providers.” We encourage the CDC to look



forward and create a resource meeting current priorities and future needs, that are influenced to a large extent by the COVID-19 pandemic. We hope CDC will address these ME/CFS priorities with the same energy, resources, and aggressive timelines that resulted in the [Evaluating and Caring for Patients with Post-COVID Conditions: Interim Guidance](#).

Thank you for taking the time to review these comments and recommendations. We hope to continue to be a trusted partner in this process. Once again, we strongly encourage you to build upon these first steps of collaboration and dialogue and continue, in that spirit, to rewrite this review.

Please don't hesitate to contact me or our organization if there is any way we can assist in this effort.

Sincerely,

Oved Amitay  
President and CEO  
Solve ME/CFS Initiative

*Additional comments regarding Docket No. CDC-2021-005 from members of the ME/CFS Community:*

Comment #1:

The messaging to practitioners in this review of the scientific literature of ME/CFS remains unchanged since the 1970's and is unacceptable: ME/CFS doesn't really exist, and most of your patients, primarily women, probably have something else, most likely depression. To stop their whining, try prescribing GET and/or CBT. All those thousands of studies about the biological processes ME/CFS is disturbing, PEM as a defining symptom, and other possible treatments? It's just noise. Ignore it. You are completely absolved of any responsibility to grapple with this literature or spend much time caring for patients with ME/CFS. This is how I interpret the report's message to practitioners.

And I can report the messaging is reaching practitioners without missing a beat. Most of the practitioners I sought treatment from since the 1990's reiterated some version of the above message: "You know, it's controversial whether or not this illness really exists"; "Even if you are diagnosed, there's nothing anyone can do"; "You'll probably have to get a specialist to diagnose you to be covered by your insurance"; "Fatigue? Oh, you have depression"; "Only cardiac patients have orthostatic intolerance. I'm not giving you a tilt table test"; "You look terrible today. I think you must have diabetes" (I didn't). I could continue for pages listing the variations on The Message I have heard from practitioners. If this report is not scrapped, I fully expect I and other patients will continue to hear iterations of this message when we seek care. Given the tidal wave of long COVID patients that's about to hit, this report does not bode well for their care, either.

The GP who pointed out I needed to see a specialist did not lift a finger to refer me to one or help me to search for one. I did all that work myself. The closest doctors near me who knew anything



about ME/CFS were a 4-6 hours' drive away (one way, so double those numbers for the round trip to and from the doctor's office). I live in a city in the US with a population over 200,000. One of those doctors was so overwhelmed, her staff let me know she couldn't take on any more patients. When I wrote the doctor a letter, she kindly agreed to see me after a six months' wait. My natural killer cell count was 119 by that point and dipped a few times during the period she monitored it, dropping to 96 at one point. My ATP was low, too. My lymph nodes swelled in cycles the way they did when I'd had mono. I had to turn down an invitation by my employer to apply for a full-time job by that point and have remained working part-time at a fraction of the full-time salary. Eventually, the long car drives were intolerable. The landscape of informed practitioners in my city and region has not changed since this odyssey to find an informed doctor started, around 2003.

Anecdotally, I and most patients can report that years of GET and CBT have worsened our ME/CFS symptoms while we have seen improvement through avoiding both. My symptoms worsened 24-48 hours after exercise, but my legs also went numb during exercise, a terrifying situation if I was exercising away from home. I would have to sit on the ground until feeling returned and hope I could make it back home.

It has also taken years to wean off anti-depressants and anti-anxiety medications that never eased my symptoms and made them significantly worse or caused intolerable side-effects while, for me, delaying an orthostatic intolerance diagnosis that could be treated. The last therapist I saw insisted we refer to fibromyalgia, which I also have, as "fibby" to make it less large in my mind and more palatable to my friends and relatives when talking about it with them. CBT, I realized, is only as good as its practitioner and helpful in proportion to how much the practitioner knows about ME/CFS. In this instance, it was ultimately harmful as it followed the same path of advising dismissal and silence suggested by the report. Training appears to be woefully lacking and needed for CBT to be practiced effectively for ME/CFS.

In general, the report does not acknowledge the context of ME/CFS, its history, its difficulties being taken seriously and why. As an academic, I value objectivity, logic, facts, fairness and understand striving for objectivity. But ME/CFS's history is too problematic to leave out at least some mention of its context. By doing so, the investigators missed an opportunity to show they are aware of it and wish to avoid the same pitfalls as has happened in the past. Instead, they have ended up going down the same path of dismissing the disease. Leaving out any mention of this context compounds the problem as it then appears investigators ventured down this path because of the same reasons and blind spots illnesses that affect primarily women garner dismissing the illness. And, worse, the objectivity ends up looking like just a thin veil trying to disguise how little the illness, its patients, and its researchers are respected.

Most notably, what else is missing in the report is highlighting the need for more funding for research. This report failed to do that. For instance, the review pinpoints problems with the research it focused on, such as small data samples. A constructive analysis of this valid issue would emphasize the need for more research and better funding for research with more data and look at the root causes for the lack of funding for such research in the first place or at least suggest this lack of funding be further investigated. Instead, the investigators raise questions about the need for research into the harm done by diagnosing the illness. This shameful recommendation and avoiding addressing the root causes of lack of research funding for ME/CFS is erasure of the illness and its patients, a name for real biological symptoms, the research done so far, and the ability to seek disability. Such an approach makes crystal clear the report is not about building on



what we know, as limited as the investigators conclude that may be, but about erasing what we know and the illness as real. And no one has to be held accountable for lack of funding and support. I have no faith in the objectivity, logic, and constructive intentions of this review group as a result.

A constructive rather than destructive approach to this review would have avoided at all cost erasure of the illness, its patients, often women, and its researchers. It would acknowledge ME/CFS's difficult context. Language of erasure has absolutely no place in this report and only perpetuates the myths, misperceptions, and inadequate care ME/CFS patients have endured for decades. The report maintains the terrible and truly harmful status quo for ME/CFS treatment.

Comment #2:

How disappointing that the research is so inadequate. What a letdown. Even I already knew that GET and CBT aren't appropriate treatments for chronic fatigue syndrome. I was hoping for a real breakthrough. From the comments on the CDC website, other countries have made some legitimate progress. Canada seems to have identified blood cell discrepancies.