

Overlapping Disorders:

Chronic Fatigue Syndrome, Fibromyalgia Syndrome Multiple Chemical Sensitivity & Gulf War Syndrome

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Chronic Fatigue Syndrome (CFS), also known as Chronic Fatigue and Immune Dysfunction Syndrome (CFIDS), Fibromyalgia Syndrome (FMS), Multiple Chemical Sensitivity (MCS), and Gulf War Syndrome (GWS) share many of the same symptoms, as described below, and often occur together, but they differ greatly in the methods used for their diagnosis and treatment. Which of these diagnoses a person receives usually depends on the type of specialist he or she sees. CFS is most likely to be diagnosed by internists or infectious disease specialists, FMS by rheumatologists, and MCS by occupational and environmental medicine physicians. Gulf War Syndrome is seen mostly by military and VA physicians but--even though the top 10 symptoms they report are all common to CFS, FMS and MCS--they call them "unexplained" and refuse to even screen for any of these disorders.

CFS is defined by the US Centers for Disease Control "for research purposes" as persistent or relapsing fatigue lasting greater than six months that is unexplained by any other physical disorder. This fatigue also must occur in combination with at least four of the following: 1) short term memory loss, 2) sore throat, 3) tender lymph nodes in neck or armpit, 4) muscle pain, 5) joint pain without swelling or redness, 6) headaches, 7) unrefreshing sleep, or 8) "malaise" that lasts more than 24 hours after exercise. CFS may develop at any age but usually starts in mid-life, often in conjunction with a flu-like illness, and is diagnosed more frequently in women. Numerous biochemical abnormalities have been identified in CFS patients but none as yet are considered diagnostic. Many treatments are available, mostly for specific symptoms or deficiencies, but outcomes vary and no cure is known. Avoiding stressors of all kinds is primary.

FMS is defined by chronic muscle and joint pain on both sides of the body, pain above and below the waist, and pain anywhere along the spine. It is usually associated with disrupted sleep, chronic fatigue, cognitive problems, and many other variable symptoms. According to the American College of Rheumatology, FMS affects about 3% of the adult U.S. population and, like CFS and MCS, is much more common in women. The diagnosis is confirmed with a brief physical exam that involves the testing of 18 pressure (or tender) points. As with CFS and MCS, the onset of FMS may be gradual or sudden. Sudden onset is usually associated with physical injury or trauma, such as a car accident or difficult childbirth, although FMS also may be initiated by infections or chemical and drug exposures. Treatments focus on relieving

pain, avoiding stress, improving sleep and correcting hormonal imbalances. Outcomes vary and no cure-all is known.

MCS, like CFS, is diagnosed by the patient's history and the consideration of other possible chemical sensitivity disorders like lupus and porphyria. It is defined by multiple symptoms affecting multiple organs (such as the nose, eyes, lungs, and central nervous system) that wax and wane in response to multiple chemical exposures at or below previously tolerated levels. MCS usually starts from a chronic (long lasting) or acute (short but high level) exposure to one or more "sensitizing" toxins such as formaldehyde, the pesticide Dursban, and carbonless copy paper. This initial sensitivity then spreads, with many other low-level exposures triggering similar symptoms. These triggers may be inhaled (like perfume), ingested (like food, alcohol and drugs), or absorbed by the skin (like detergent residues and pesticides). A random survey of 4,000 adults in California by the state's Department of Health Services in 1995--funded by the US Agency for Toxic Substances and Disease Registry--found 15.9% complained of being "unusually sensitive" to "everyday chemicals" in common household products and 6.3% said they'd been given the diagnosis of MCS or Environmental Illness by a doctor. Similar percentages were found again in 1996 when the same questions were asked of 4,000 others. Treatment focuses on avoiding and controlling the exposures that trigger symptoms, combined with exercise and sauna as tolerated, and nutritional supplements to address common vitamin and mineral deficiencies.

CFS, FMS and MCS occur together in approximately 1/3 to 2/3 of all cases, according to the first study of this overlap done in 1994. The MCS overlap was perfectly symmetrical, with up to 67% of both CFS and FMS patients reporting a worsening of symptoms following exposure to air pollution, cigarette smoke, solvent fumes or perfumes. The FMS overlap also appears symmetrical, with 67% of both MCS and CFS patients reporting muscle weakness and 63% to 77% complaining of muscle and joint pain. And despite using an older (1988) and narrower definition of CFS, the study found CFS in 70% of FMS and 30% of MCS patients. Using the broader 1994 criteria for CFS, the overlap is much greater: a study of 100 new MCS patients found 88% also had CFS, 49% had FMS and 47% had all three! These extensive overlaps highlight the need to screen patients for all three disorders whenever any one is suspected.

More research is needed to see if Gulf War veterans and civilians who meet the criteria for more than one of CFS, FMS and/or MCS are suffering from separate disorders or just variations of one underlying but as yet defined common syndrome. All three seem to share reduced tolerance for a diverse range of physical, biological, chemical and mental stressors. In addition to chemical sensitivity, many also report heightened sensitivity to bright lights, loud noises, spicy foods, and physical touch, vibration and/or pain. Given how little is yet known about these overlaps, however, most physicians, insurers, attorneys and support groups continue to regard CFS, FMS, MCS and GWS as separate conditions.

It is very important that anyone suspected of having any one of these overlapping syndromes be screened for all of the others as well as for other possible underlying complications and causes of their symptoms such as inherited mast cell or porphyrin disorders. Failure to do a thorough differential diagnosis may have serious consequences, as health care providers may overlook potentially treatable conditions that present with similar symptoms or recommend inappropriate treatments. Since drug sensitivities are common in all these disorders, for example, physicians who prescribe medications for CFS/FMS/MCS patients are advised to start at way below the normal dose and increase slowly only if it is well tolerated. Thorough documentation of all signs, symptoms and diagnoses also is critical for patients seeking workplace accommodation or workers' compensation, Social Security and other disability benefits, or insurance coverage.

For additional information on the diagnosis and treatment of these overlapping disorders and referral services, please contact the following national organizations:

MCS Referral & Resources

www.mcsrr.org

618 Wyndhurst Avenue #2, Baltimore, MD 21210
410-889-6666, fax 410-889-4944

CFIDS Association of America

www.cfids.org

PO Box 220398, Charlotte, NC 28222-0398
800-442-3437, fax 704-365-9755

Fibromyalgia Network National Gulf War Resource Center

PO Box 31750, Tuscon, AZ 85751-1750 1224 M Street NW, Washington, DC 20005

800-853-2929, fax: 520-290-5550 202-628-2700 x162, fax 202-628-6997

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