

10 year surveillance (2017) – [Chronic fatigue syndrome/myalgic encephalomyelitis \(or encephalopathy\) \(2007\) NICE guideline CG53](#)

Stakeholder consultation comments form - proposal for ‘no update’

Consultation on the proposal for ‘no update’ opens on: 9am Monday, 10 July 2017

Comments on proposal to be submitted: no later than 9am Monday, 24 July 2017

<p>Please enter the name of your registered stakeholder or respondent organisation below.</p> <p>Please use this form for submitting your comments to NICE.</p> <ol style="list-style-type: none"> 1. Please put each new comment in a new row. 2. Please note – we cannot accept comments forms with attachments such as research articles, letters or leaflets. If we receive forms with attachments we will return them without reading the comments. If you resubmit the comments on a form without attachments, this must be by the consultation deadline. 3. If you wish to draw our attention to published studies, please supply the full reference. 4. NICE is unable to accept comments from non-registered organisations. If you wish your comments to be considered please register via the NICE website or contact the registered stakeholder organisation that most closely represents your interests and pass your comments to them. 	
Organisation name – Stakeholder or respondent	Action for M.E.
Disclosure Please disclose whether the organisation has any past or current, direct or indirect links to, or receives funding from, the tobacco industry.	N/A
Name of commentator:	Katie McMahon, Policy Officer

[Developing NICE guidelines: the manual](#) gives an overview of the processes used in surveillance reviews of NICE clinical guidelines.

ID	Questions	Overall response yes / no	Comments Please insert each new comment in a new row
1	Do you agree with the proposal not to update the guideline?	No	<p>Action for M.E. strongly disagrees with the proposal not to update the guideline for the following reasons:</p> <ol style="list-style-type: none"> 1. There is not, at the present time, a conclusive evidence base for treatments for CFS/M.E., including those recommended in the guideline, such as CBT and/or GET. 2. The current evidence base has led major international health agencies, including the Centers for Disease Control and Prevention in the US, to alter their guidance regarding CBT and GET. 3. NICE has an ethical obligation to present a full, accurate and balanced picture of current international clinical practice when it comes to managing and treating CFS/M.E. The existing guideline does not do this. <p>We provide further details on each of these points below.</p> <hr/> <p>1. There is not, at the present time, a conclusive evidence base for treatments for CFS/M.E., including those recommended in the guideline, such as CBT and/or GET.</p> <p>The guideline must reflect that there is a mixed evidence base for its treatment recommendations of CBT and GET.</p> <p>The research published since the last review of this guideline has provided a range of different findings. Whilst there have been some which may support the recommendations in CG53, others challenge those recommendations. There is no consensus.</p> <p>The current guideline states that “Cognitive behavioural therapy (CBT) and/or graded exercise therapy (GET) should be offered to people with mild or moderate CFS/M.E. and provided to those who choose these approaches, because currently these are the interventions for which there is the clearest research evidence of benefit”. [NICE 2007, <i>CFS/ME: Diagnosis and management</i>] The guideline does not offer further information on the quality, quantity and validity of this research evidence.</p>

ID	Questions	Overall response yes / no	Comments Please insert each new comment in a new row
			<p>As outlined in the NICE proposal, the data from the PACE trial is currently part of an ongoing debate over the quality of the trial. The meta-analysis Cochrane review on GET [Larun et al 2017, <i>Exercise therapy for chronic fatigue syndrome</i>] concludes that there is a significant effect on fatigue and physical functioning only when the PACE data is included. The review also recognises the “considerable heterogeneity” in results across all trials, and recommends further research to explore this.</p> <p>Other reviews have concluded that exercise for patients with CFS/M.E. can be harmful [Twisk 2017, <i>Dangerous exercise. The detrimental effects of exertion and orthostatic stress in Myalgic Encephalomyelitis and chronic fatigue syndrome</i>, Physical Medicine and Rehabilitation Research Vol 2(1)], indicating that risks of potential harm should be considered when determining appropriate treatment for patients with CFS/M.E. The heterogenous results outlined in the Cochrane review (2017) also indicate that sub-groups of patients are either not benefitting from, or are reacting adversely to, GET.</p> <p>The Cochrane review on CBT [Price et al 2008, <i>Cognitive behaviour therapy for chronic fatigue syndrome in adults</i>] does not include data from PACE, and states that the evidence base is “limited to a small group of studies”, and that there is “a lack of evidence on the comparative effectiveness of CBT alone or in combination with other treatments.”</p> <p>The NICE proposal states that the ‘direction of effect’ is consistent across the evidence base, showing improvement for some patients following CBT or GET intervention. The proposal further states that, should the PACE data be downgraded or set aside in a new review, other evidence from RCTs and systematic reviews shows benefits from CBT and GET.</p> <p>The guideline’s core recommendation on treatment, that CBT and/or GET should be offered to people with mild or moderate CFS/M.E, does not acknowledge that the results for these treatments are disputed. The guideline ought to reflect that there is a mixed evidence base for these treatments. They can help some patients, but the results demonstrating this are heterogeneous and not significant, except when a trial which is currently subject to scientific scrutiny as to the validity of its results is included.</p>

ID	Questions	Overall response yes / no	Comments Please insert each new comment in a new row
			<p>2. The current evidence base has led major international health agencies, including the Centers for Disease Control and Prevention in the US, to alter their guidance regarding CBT and GET.</p> <p>Major international health agencies in the US have altered their guidance, demonstrating the lack of consensus resulting from the evidence base, which has led to varying policy and practice in the management and treatment of CFS/M.E.</p> <p>We comment above on the mixed evidence base for efficacy of CBT and GET and our concern that the NICE proposal to maintain CG53 without updating means excluding up-to-date information about the current body of research regarding best clinical practice for patients with CFS/M.E. The mixed (and developing) evidence base is fostering ongoing debate in the academic and clinical community over what forms of intervention ought to be recommended for patients and treatment guidance is changing as a result in other parts of the world.</p> <p>US health agencies, such as the Centers for Disease Control and Prevention, have changed their guidance on the condition to remove references to CBT and GET [Centers for Disease Control and Prevention, <i>Myalgic Encephalomyelitis/Chronic Fatigue Syndrome</i>, https://www.cdc.gov/me-cfs/index.html accessed 21 July 2017] and the New York State Health Commissioner recently informed clinicians that CBT/GET were recommended “in the past” [https://drive.google.com/file/d/0B37JHmPXER6JZkZRd0hIaIA2bUE/view accessed 21 July 2017]. These changes in policy and practice signal a divergence in what conclusions can be drawn from the evidence base with regard to treatment and management approaches.</p> <p>The changing stance of US medical agencies has occurred since the 2015 Institute of Medicine report, <i>Beyond Myalgic Encephalomyelitis/Chronic Fatigue Syndrome: redefining an illness</i> [Institute of Medicine 2015, Beyond Myalgic Encephalomyelitis/Chronic Fatigue Syndrome: Redefining an Illness, National Academies Press]. This report proposed tighter diagnostic criteria, and concluded that “it is clear from the evidence compiled by the committee that M.E./CFS is a serious, chronic, complex, multisystem disease that frequently and dramatically limits the activities of affected patients.” These conclusions</p>

ID	Questions	Overall response yes / no	Comments Please insert each new comment in a new row
			<p>have resulted in US practice moving away from the behavioural treatments that were advocated previously.</p> <p>It is not a question of one agency being right, and another being wrong. The reality is that it would be unethical to maintain a NICE guideline that fails to inform patients of the range of views on biological care and management strategies for CFS/M.E.</p> <p>The current CG53 was issued in 2007 when there was a greater consensus around recommended interventions. The context is now much changed, and continuing to recommend CBT and/or GET without mentioning that there is not a clinical consensus around their efficacy is to provide incomplete guidance to clinicians and misrepresent current international practice to patients.</p>

			<p>3. NICE has an ethical obligation to present a full, accurate and balanced picture of current international clinical practice when it comes to managing and treating CFS/M.E. The existing guideline does not do this.</p> <p>Not acknowledging the inconclusive and disputed evidence of the effectiveness of CBT and GET has serious implications for patients accessing medical care and for clinicians obtaining informed consent.</p> <p>Medical ethics place a duty on health organisations to ensure that patients can access healthcare, even in cases where there is diagnostic uncertainty. Care cannot be withheld due to uncertainty over what form of care would be most appropriate and effective for the patient. Additionally, patients have a right to autonomy, exercised through informed consent to a particular health intervention.</p> <p>These ethical principles are endorsed in NHS England’s Core Principles. [NHS Core Principles, http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhscoreprinciples.aspx, accessed 21 July 2017] Principle 1 states that “the [NHS] is designed to diagnose, treat and improve both physical and mental health. It has a duty to each and every individual that it serves and must respect their human rights.” Principle 4 states that “patients... will be involved in and consulted on all decisions about their care and treatment.” This right to consultation is further enshrined in NHS policy on Shared decision making. [NHS, <i>Shared Decision Making</i>, https://www.england.nhs.uk/ourwork/pe/sdm/, accessed 21 July 2017]</p> <p>In Appendix A of the NICE proposal, under <i>Shared decision-making</i> 1.1.1.1 it is stated, that in order to ensure shared decision-making, the healthcare professional should “provide information about the range of interventions and management strategies as detailed in this guideline.” If there is additional information that is not detailed in the guideline, then professionals could be in the situation of acting in accordance with the guideline but not complying with NHS England’s Core Principles.</p> <p>In accordance with the NICE guideline as it stands, a clinician would recommend CBT and/or GET as the best-evidenced interventions and the patient may agree to take part in these interventions. In such a situation, the patient is not being told all the relevant information that would impact on their decision when consenting to these treatments. The patient is not aware that:</p>
--	--	--	--

			<ul style="list-style-type: none"> • a meta-analysis of the overall body of evidence produces significant results in favour of GET only when the data from a disputed trial is included; the PACE trial is sufficiently disputed that the NICE proposal accounts for the possibility of these results being downgraded or set aside • the overall body of evidence in favour of CBT, in its most up-to-date Cochrane review, is not significant • medical agencies internationally have considered this evidence base and produced conflicting guidance. <p>This information is sufficiently significant that it can be reasonably concluded that the patient is not able to give informed consent in making this decision. It also contravenes the NICE consensus statement on shared decision making [NICE, <i>Shared Decision Making Collaborative: A consensus statement</i>, https://www.nice.org.uk/Media/Default/About/what-we-do/SDM-consensus-statement.pdf accessed 21 July 2017] which states patients should be able to have “informed preferences”, based on the “options, outcomes and uncertainties” of care or treatment options.</p> <p>Furthermore, when the patient is not informed of alternative care interventions, their access to these interventions is effectively withheld.</p> <p>In giving an unconditional recommendation of CBT and/or GET, the guideline precludes the provision of other healthcare approaches, such as biological care in the form of pharmacological treatments for individual symptoms or other techniques for managing symptoms. Given the international difference over recommended approaches, patients have a right to access these alternatives as a means to improving their condition. Inasmuch as the guideline does not acknowledge these alternatives, a patient is prevented from accessing this potentially beneficial healthcare. In this way, the current NICE guideline could prevent patients from improving their health.</p> <p>In recommending CBT and GET as interventions, and not providing more information on alternatives, the guideline is also missing an opportunity to embed a personalised medicine approach in the treatment of CFS/M.E. As stated above, it is unethical to withhold access to treatments that may improve the health of patients. Suggesting a range of treatments, and acknowledging that their efficacy varies in different patient groups, increases the likelihood of a patient accessing a course of treatment that will be effective for them. In continuing to recommend CBT and/or GET for patients in a ‘one size fits all’ approach, the current</p>
--	--	--	---

			<p>guideline limits the likely effectiveness of treatment for patients, as only the sub-group which responds positively to these treatments will see their health improve.</p> <p>In Wales, the NHS is adopting principles of prudent healthcare to ensure greater value from healthcare systems for patients. An underlying principle is that “any service or individual providing a service should achieve health and wellbeing with the public, patients and professionals as equal partners through coproduction.” [Welsh Government, <i>Prudent healthcare</i>, http://gov.wales/topics/health/nhswales/prudent-healthcare/?lang=en accessed 21 July 2017] It is difficult to see how this can be achieved if the NICE guideline does not provide either clinicians or patients with the current international understanding to underpin decision-making.</p> <p>The guideline states that CBT and GET are currently “the interventions for which there is the clearest research evidence of benefit.” This is largely down to a lack of research on alternative approaches. For example, many patients with CFS/M.E. report that pacing is helpful in managing their condition. Action for M.E.’s 2014 patient survey found that 85% found pacing helpful, 12% found it made no change and 4% said their condition got worse (cf. 54%, 34%, and 12% for CBT and 48%, 19%, and 24% for GET respectively) [Action for M.E. 2014, <i>M.E.: Time to deliver</i>, https://www.actionforme.org.uk/uploads/pdfs/me-time-to-deliver-survey-report.pdf], CG53 acknowledges this patient opinion, but states that healthcare professionals should advise patients that “there is insufficient research evidence on the benefits or harm of pacing.” The guideline ought to identify alternatives to CBT/GET as an area for further research in order to ensure that there is a well-rounded evidence base. This is particularly the case given the disputed nature of evidence on CBT and GET, and that US medical agencies have recommended management approaches such as pacing based on patient experience.</p> <p>The strength of patient feeling regarding CG53 is demonstrated through a petition [http://bit.ly/2tyXlmM, accessed 21 July 2017] which has gained more than 14,000 signatures as of 21 July 2017 and calls for a full review of the guideline. The experiences of people with CFS/M.E., both in the UK and internationally, support that CBT and/or GET treatments do not constitute an appropriate universal approach to effectively managing the condition and indicate the need to consider a wider range of biological treatments and other management approaches that, altogether, will offer the best efficacy in improving the health of patients.</p>
--	--	--	--

			<p>Reissuing the 2007 guidance makes it difficult for patients and clinicians to be aware of the current international context in managing M.E and make informed decisions about patient care. There is an obligation to inform patients there is not unanimity in the medical field regarding treatment and management approaches. Informed consent is not in place if healthcare professionals and patients are not comprehensively aware of the current medical position, and patients are being denied access to biological medical care or other management approaches if they are not being made aware of other options which could be potentially beneficial to their health.</p>
--	--	--	--

ID	Questions	Overall response yes / no	Comments Please insert each new comment in a new row
2	Do you agree with the proposal to remove the guideline from the static list?	Yes	<p>Action for M.E. agrees with the proposal to remove the guideline from the static list.</p> <p>There are a number of ongoing trials that are expected to conclude in the coming years that warrant more frequent review of the guideline.</p> <p>Trials into pharmacological treatments include ongoing research on HyQyia, an immunoglobulin [http://bit.ly/2gQ44oh accessed 21 July 2017] and on the immunosuppressant cyclophosphamide [https://www.clinicaltrials.gov/ct2/show/NCT02444091 accessed 21 July 2017]. Other research that has concluded called for further investigation of the antiviral valganciclovir [Montoya et al 2013, Randomized clinical trial to evaluate the efficacy and safety of valganciclovir in a subset of patients with chronic fatigue syndrome, <i>Journal of Medical Virology</i> 85(12)]. There is also a Norwegian phase III trial into the immunosuppressant Rituximab [Fluge et al 2015, <i>B-Lymphocyte Depletion in Myalgic Encephalopathy/ Chronic Fatigue Syndrome. An Open-Label Phase II Study with Rituximab Maintenance Treatment</i>, <i>PLoS ONE</i> 10(7)] taking place as of May 2017. These are just a few examples of a broad field of research listed on NHS Choices from the WHO International Clinical Trials Registry Platform [NHS Choices, <i>Chronic fatigue syndrome (CFS/M.E.): Clinical trials</i>, http://www.nhs.uk/Conditions/Chronic-fatigue-syndrome/Pages/clinical-trial.aspx, accessed 21 July 2017] which may impact on the NICE recommendations, and which ought to be considered in upcoming reviews.</p> <p>The NICE proposal also mentions that the data from the PACE trial is currently under dispute. Given that this data is used in support of the guideline's recommendations, and that there are continued re-analyses of this data and comment on the conduct of the trial, the guideline must also be in a position to be updated promptly in case the results of the trial are determined not to be valid.</p>
3	Do you have any comments on areas excluded from the scope of the guideline?	No	

ID	Questions	Overall response yes / no	Comments Please insert each new comment in a new row
4	Do you have any comments on equalities issues?	Yes	<p>According to the Equality Act 2010 Part 2 Chapter 1 Section 6, people are disabled if they have a physical or mental impairment that has a ‘substantial’ and ‘long-term’ negative effect on their ability to carry out normal daily activities. According to this definition, the vast majority of people with CFS/M.E., including those relatively mildly affected, are disabled.</p> <p>The UN Convention on the Rights of Persons with Disabilities of which the UK is a signatory, requires (at article 25 d) that health professionals “provide care of the same quality to persons with disabilities as to others, including <i>on the basis of free and informed consent</i> by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and <i>the promulgation of ethical standards for public and private health care.</i>” [our emphasis]</p> <p>We have outlined above our concerns that it is unethical not to provide clinicians and patients with a balanced current understanding of the evidence base for treatment and management approaches, and that failure to do so prevents informed consent. It is our view that to ensure compliance with article 25 d of the Convention, review and updating the guideline should not be delayed.</p> <p>Action for M.E. frequently hears from patients who are not informed of treatments that could improve their symptoms. The guideline does not translate into the provision of appropriate symptom management in practice. The NHS England Accessible Information Standard [NHS England, <i>Accessible Information: Specification</i>, https://www.england.nhs.uk/wp-content/uploads/2015/07/access-info-spec-fin.pdf accessed 21 July 2017] outlines the need for all NHS care to ensure that people with a disability are supported to communicate effectively with health and care professionals. As people with CFS/M.E. can experience cognitive difficulties it must be considered how to ensure the full range of potential healthcare approaches is presented and communicated. If clinicians are not aware of the full and balanced picture of the international medical context, and therefore cannot communicate this clearly and accurately to patients, people with CFS/M.E. may not be aware of and therefore not able to access appropriate biological medical care.</p> <p>On grounds of equality and human rights, as well as on grounds of effective healthcare, the NICE guideline must be reviewed and updated.</p>

Please email this form to: surveillance@nice.org.uk

Closing date: 9am, 24 July 2017

PLEASE NOTE:

NICE reserves the right to summarise and edit comments received during consultations, or not to publish them at all, if NICE's reasonable opinion is that the comments are voluminous, publication would be unlawful or publication would be otherwise inappropriate.