



30 April 2025

NHMRC

Scoping survey for Clinical Practice Guidelines for myalgic encephalomyelitis / chronic fatigue syndrome

Email: me_cfs@nhmrc.gov.au

Dear Secretariat,

Re: Scoping survey for Clinical Practice Guidelines for ME/CFS

The Royal Australian College of General Practitioners (RACGP) thanks the National Health and Medical Research Council (NHMRC) for the opportunity to respond to the scoping survey for the development of clinical practice guidelines for myalgic encephalomyelitis/ chronic fatigue syndrome (ME/CFS).

The RACGP acknowledges that ME/CFS is a challenging chronic condition to diagnose given that there is no confirmatory test, and diagnosis is based on symptoms and the exclusion of other illnesses.ⁱ As well as being challenging to diagnose, ME/CFS is considered to be a rarer condition with an estimated prevalence reported between 0.2% and 0.4% of the Australian population. Whilst the true prevalence is likely to be higher due to under-diagnosis of the condition, it is relatively less commonly diagnosed in the primary care setting.ⁱⁱ

We note that the proposed clinical practice guidelines will focus on the interactions between patients and general practitioners, providing referral pathways where relevant.

In addition to the standard components of an evidence-based guideline for the prevention, diagnosis and management of ME/CFS we would like to provide the following general comments.

Multi-disciplinary care

General practice is well placed to coordinate patient-centred care and provide support for patients who present with medically unexplained symptoms which may be complex and challenging to diagnose.ⁱⁱⁱ Chronic conditions make up a substantial proportion of general practice activity.^{iv}

ME/CFS may be associated with a long list of co-occurring conditions such as fibromyalgia, irritable bowel syndrome, depression, anxiety, allergies and many others.^v More than two-thirds of patients with ME/CFS in clinical trials met diagnostic criteria for mental health disorders such as anxiety, dysthymia, or depression.^{vi}

It will be important that such symptoms are addressed and treated so that the patient can better manage their ME/CFS symptoms.

It is recommended that the guideline provide statements about managing additional comorbidities that may be experienced by patients, including mental illness in the context of ME/CFS.

Quaternary prevention

The guideline may consider covering quaternary prevention – the avoidance of harm from medical interventions and medical advice.

Medical interventions might include the use of unapproved, poorly evidenced or low value therapeutics. These interventions may cause direct harm, harm through lost opportunities for better interventions, costs, inequity of access, and negative impacts on the health system.

Whilst patient choice is also important, it is equally important that patients are fully informed about the best available evidence-based care, including which treatments are still experimental, and those that should be avoided or which represent low value care.



Unnecessary medications, testing, or procedures represent low value care and can cause more harm than benefit.

Evidence based guidelines should include best practice statements for exploring treatment options, particularly those that may be new, and include information about balancing the risks associated with trying unapproved or low value therapeutics.

Management of diagnostic uncertainty

As ME/CFS is complex and challenging to diagnose and manage, it is important that patient expectations are explored and balanced with inevitable diagnostic uncertainty.

Managing uncertainty includes avoiding practicing defensive medicine, which may result in over-testing and the harms of low value care previously mentioned. In addition, diagnostic uncertainty may contribute to patient frustration due to a lack of a definitive diagnosis and/or clear treatment pathways. Stress and frustration experienced by patients can lead to them resorting to low value care options.^{vii}

It will be important that the guideline include an explanation of diagnostic uncertainty, and how this may be managed.

Exercise interventions

The debate between those that support incrementally increasing physical activity and those that support staying well within an energy envelope requires a dispassionate examination of trial evidence, particularly the multiple long-Covid trials (388 registered trials)^{viii} that are emerging and are likely to provide additional evidence in the near future.

Surveys by patient groups of their members have suggest that incremental physical activity may be harmful to some people with ME/CFS and advocate against such programs. It is possible that these experiences may be due to inappropriately planned or progressed exercise programs, possibly undertaken independently or under supervision from a person without appropriate experience, or subgroups within the spectrum of ME/CFS who are more vulnerable to more severe post-exertional malaise.

It will be important that implementation of any treatment involving an increase in physical activity is very sensitive to these concerns and the guideline must raise awareness that many patients and carers will be aware of the strong advocacy specifically against such programs. Trust and acknowledgement of these concerns, with appropriate caution will necessarily be a crucial part of guideline recommendations.

The RACGP thanks the NHMRC for the opportunity to provide comment. If you have any queries regarding this submission, please contact qualitycare@racgp.org.au

Yours sincerely

Dr Michael Wright
President



References

ⁱ Centres for Disease Control and Prevention. Myalgic Encephalomyelitis / Chronic Fatigue Syndrome <https://www.cdc.gov/me-cfs/hcp/diagnosis/> [accessed 16/04/2025]

ⁱⁱ Orji N, Campbell J, Wills K, et al. 2022 Prevalence of myalgic encephalomyelitis / chronic fatigue syndrome (ME / CFS) in Australian primary care patients: only part of the story? *MBC Public Health* 22(1516). <https://bmcpublihealth.biomedcentral.com/articles/10.1186/s12889-022-13929-9> [accessed 22/04/2025]

ⁱⁱⁱ Australian Government Department of Health 2020 National Strategic Action Plan for Rare Diseases <https://www.health.gov.au/resources/publications/national-strategic-action-plan-for-rare-diseases?language=en> [accessed 16/04/2025]

^{iv} Australian Institute of Health and Welfare 2024. The ongoing challenge of chronic conditions in Australia <https://www.aihw.gov.au/reports/australias-health/chronic-conditions-challenge> [accessed 16/04/2025]

^v Carruthers BM, Kumar A, Ke Meirleir KL et al 2003 Myalgic encephalomyelitis / chronic fatigue syndrome: Clinical working case definition, diagnostic and treatment protocols. *Journal of Chronic Fatigue Syndrome*, 11(2): 13 doi:10.1300/J092v11n01_02 https://www.tandfonline.com/doi/abs/10.1300/J092v11n01_02 [accessed 22/04/2025]

^{vi} Wright A, Fisher PL, Baker N, et al. 2021 Perfectionism, depression and anxiety in chronic fatigue syndrome: A systematic review. *Journal of Psychosomatic Research* 140: 110322 <https://www.sciencedirect.com/science/article/abs/pii/S0022399920308849#:~:text=Irrespective%20of%20aetiolo%20debate%2C%20adults,anxiety%20%5B29%2C30%5D>. [accessed 22/04/2025].

^{vii} Royal Australian College of General Practitioners 2023 Managing uncertainty. <https://www.racgp.org.au/getattachment/ada86933-c604-4d1c-9b1b-567c4816b696/Managing-uncertainty.aspx> [accessed 22/04/2025]

^{viii} Ashraf N, Shaar BA, Taha RM, et al. 2023 A systematic review of trials currently investigating therapeutic modalities for post-acute COVID-19 syndrome and registered on WHO International Clinical Trials Platform. *Clin Microbiol Infect*. 2023 May;29(5):570-577. doi: 10.1016/j.cmi.2023.01.007 <https://pubmed.ncbi.nlm.nih.gov/36642173/> [accessed 22/04/2023]