



The quarterly newsletter of the
**Chronic Fatigue Syndrome &
 Fibromyalgia Support Group of
 Dallas-Fort Worth**


Volume 4, No. 1, January 2002

A POSSIBLE NEW NAME: CHRONIC NEUROENDOCRINEIMMUNE DYSFUNCTION SYNDROME (CNDS)

Almost two years ago the CFS Coordinating Committee (CFSCC), which operates under the umbrella of the Department of Health and Human Services (DHHS), established a Name Change Workgroup (NCW).

Nominations were sought from the patient and medical community for three patient advocates, three CFS researchers, and three CFS clinicians to serve on the NCW. Patient representatives are John Herd, Kim Kenney, and Carol Leonard. Researchers are Leonard Jason, Ph.D., Nancy G. Klimas, M.D., and ad hoc researchers as needed. Clinicians are Daniel Kahn, M.D., Charles Lapp, M.D., and Susan Levine, M.D. Two DHHS members also serve on the NCW. Dr. Arthur Lawrence functions as a liaison from the DHHS, and Dr. Patrick McNeilly assists with logistical functions.

The NCW's purpose has been to study name change issues and make recommendations for a new name for "chronic fatigue syndrome." The NCW is an advisory workgroup and has authority only to recommend, not enact, a name change. Towards that goal, the workgroup has been meeting every two weeks for the past 18 months to build consensus on an alternative to "chronic fatigue syndrome."

The group has released the following draft of its recommendations and is interested in feedback from persons with CFIDS, medical professionals and other interested parties. The alternative term proposed by the group is Chronic Neuroendocrineimmune Dysfunction Syndrome (CNDS). The working group will prepare final recommendations for the next meeting of the CFSCC.

Note that this recommendation is still in the draft stage. This is not yet the official recommendation to the CFSCC, much less an announcement of a new name. There is still a long way to go in this very important process. You can be an important part of this process. After studying the NCW's recommendation, please fill out the survey on page six and mail it to the address given on the survey by January 7, 2002.

Those who want more information on this process, including responses it has generated, can do a search of the archives at www.co-cure.org. Search using "CFSCC" in the text area and "Name" in the subject line area. The time frame for the search is the last two years.

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HOMEMADE REPLACEMENT FOR GOOKINAID

- 1 cup Spring Water
- 1 cup Seltzer Water
- 1/4 tsp Sea Salt
- 1/4 tsp "No Salt" Salt Substitute (potassium)



Drink 3 - 4 glasses sipped over ice daily. Observe blood pressure response. Consider stopping if blood pressure rises above 140/90.

The potassium has an unpleasant taste. One member adds several drops of stevia and puts an herbal tea bag in the empty 2 liter bottle she uses to hold this mixture. (Doesn't alter the electrolyte balance, but gives it flavor: peach, peppermint, raspberry zinger, etc.)

Gookinaid increases blood volume, reducing the symptoms of OI/NMH—lightheadedness upon standing or in a warm environment (i.e. bath). For more information, see "Drink Gookinaid to Increase Blood Volume;" Vol. 3, Issue 1, Jan, 2001

NATIONAL GROUPS RESPOND TO DRAFT

How are the leading CFS/FM organizations responding to the new name proposed in the workgroup's draft? Kim Kenney, CEO of **The CFIDS Association of America**, serves on the NCW and helped formulate it. **The National CFIDS Foundation** says, "the workgroup ... turned out a good product and for that deserves our commendation." **The United Kingdom ME**

Association states, "CFS needs to be removed from the medical language as soon as possible, and the suggested change may, in fact, be the best way of achieving this. Widespread international adoption of the use of the term CNDS could also help to stimulate far more interest amongst researchers." co-cure.org

DRAFT OF THE RECOMMENDATION OF THE NAME CHANGE WORKGROUP (NCW)

I. INTRODUCTION

The illness known as chronic fatigue syndrome (CFS), has over the years been referred to by a variety of names. Because the names for this illness are widely believed to be inadequate, the CFS Coordinating Committee established the (NCW). Its charge was to investigate name change issues and present name change recommendations. The NCW reviewed the published CFS/ME literature, communicated with researchers, patients, and physicians, and conducted a survey to further gauge opinions of various stakeholders. Based on these communications, the NCW has established that there are several different groups of stakeholders with strong feelings about changing the name. To assess all the data, the NCW held regular discussions for 13 months and debated the relative merits of stakeholder concerns, related issues and a variety of potential names. Based on our discussions, the NCW concluded the following:

1. Many patients and physicians believe that the current name, CFS, too narrowly focuses upon a single, poorly defined symptom (fatigue) and profoundly promotes misunderstanding of the illness.
2. Patients feel the name CFS has substantially contributed to the disparaging manner in which they are perceived and treated by physicians, family, and the public in general. They also believe this misunderstanding has directly and negatively impacted the quality of medical care and support they are able to obtain. Research by Dr. Jason validates the adverse influence of name impact.
3. No one name is the obvious choice based on the current state of the science, nor can a single name fulfill all of the demands of all interested parties. Therefore, we recommend that the new name serve as an umbrella term. Under that term, subgroups of patients can be more accurately stratified according to variations in illness presentation, pathophysiology, results of diagnostic testing, or other factors.
4. This condition is a serious illness, which like other significant and recognized conditions, is best categorized as a syndrome. This syndrome is a collection of signs and symptoms that when taken as a whole under the appropriate conditions, defines this illness. Utilization of this approach in this condition is analogous to the medical community's traditional approach

to other serious, organic syndromes such as Organic Brain Syndrome, Sjogren's Syndrome, and Multiple Sclerosis.

II. FACTORS AND FORMULATION OF A NEW NAME

Formulation of a new name was guided by at least four important principles. **First**, the new name must not imply that the etiology of this syndrome or its pathogenesis is understood by the biomedical community. **Second**, the name must reflect the common symptoms reported by most patients with this condition without overemphasizing any one system. **Third**, data which has been published in peer-reviewed literature must lend support to the new name. **Fourth**, the name must include language that reflects the fact that the illness is chronic.

The number of symptoms reported by patients with this syndrome is very large. However, most of the commonly reported symptoms are associated with or may be indicative of an aberration or dysfunction in one or more of these systems: neurologic, neuroendocrine, and the immunologic systems. The following selected scientific publications provide a sound basis for a new name that is based on common patient symptoms associated with these systems. The articles were selected because they have withstood scientific scrutiny and represent critical findings. There are other publications available, but the chosen articles are widely respected, cited, and felt to be representative of the current understanding of the science. For purposes of this document, the articles have been categorized into their relevant subsections pertaining to each of the systems.

A. NEUROLOGIC

Autonomic nervous system (including orthostatic intolerance)

Several authors have published findings demonstrating that some of the symptoms seen with this syndrome are associated with autonomic nervous system dysfunction.

Bou-Holaigah I, Rowe PC, Kan J, Calkins H. The relationship between neurally mediated hypotension and the chronic fatigue syndrome. *JAMA* 1995; 274:961-967.

Schondorf R, Freeman R. The importance of orthostatic intolerance in the chronic fatigue

syndrome. *Am J Med Sci* 1999;317(2):117-123.

Freeman R, Komaroff A. Does the chronic fatigue syndrome involve the autonomic nervous system? *Am J Med* 1997;102:357-364.

NEUROENDOCRINE SYSTEM

The best studied evidence of neuroendocrine dysfunction involves the hypothalamic-pituitary-adrenal axis.

Demitrak MA, Dale JK, Strauss SE, et al. Evidence for impaired activation of the hypothalamic-pituitary-adrenal axis in patients with chronic fatigue syndrome. *J Clin Endocrinol Metab* 1991;73:1223-1234.

Scott LV, Medbak S, Dinan TG. Blunted adrenocorticotropin and cortisol responses to corticotropin-releasing hormone stimulation in chronic fatigue syndrome. *Acta Psychiatr Scand* 1998;97:450-457.

NEUROCOGNITIVE

Neurocognitive symptoms are reported with relatively high frequency in this syndrome. Many meritorious articles have been published, but at least one seems to be scientifically robust and has not been substantially challenged by other publications.

DeLuca J, Johnson SK, Ellis SP, Natelson BH. Cognitive functioning is impaired in patients with chronic fatigue syndrome devoid of psychiatric disease. *J Neu Neurosurg Psy* 1997;62:151-155.

SLEEP STUDIES

Complaints of sleep disturbances are common in this patient group. Two independent research teams have published separate studies supporting the high-frequency of sleep dysregulation. These studies have also found the sleep dysregulations are not related to psychiatric disorders, and there are differences between patients diagnosed with this syndrome versus multiple sclerosis or normal controls. Buchwald D, Pascualy R, Bombardier C, Kith P. Sleep disorders in patients with chronic fatigue. *Clin Infect Dis* 1994;18(suppl. 1):S68-72

Krupp LB, Jandorf L, Coyle PK, Mendelson WB. Sleep disturbance in chronic fatigue syndrome. *J Psychosom Res* 1993;37:335-331.

continued on page 3

B. THE IMMUNOLOGIC SYSTEM

Several articles had been published investigating the relationship between the immunologic system and chronic fatigue syndrome. The best validated work and most consistent findings demonstrate decreased function of natural killer cells and reduced responses of T-cells to mitogens and other specific antigens. The literature also supports evidence of chronic immune activation in CFS, with increasing emphasis on cytokine dysregulation.

Caligiuri M, Murry C, Buchwald D, et al. Phenotypic and functional deficiency of natural killer cells in patients with chronic fatigue syndrome. *J Immunol* 1987;139:3306-3313.

Hanson, S.J., Gause, W., & Natelson, B. (2001). Detection of immunologically significant factors for chronic fatigue syndrome using neural-network classifiers. *Clinical and Diagnostic Laboratory Immunology*, 8, 658-662.

Klimas NG, Salvato FR, Morgan R, Fletcher MA. Immunologic abnormalities in chronic fatigue syndrome. *J Clin Microbio* 1990;28:1403-1410.

Patarca R, Klimas N, Sandler D, Garcia MV, Fletcher MA. Interindividual immune status variation patterns in patients with chronic fatigue syndrome: association with gender and tumor necrosis factor system. *J of CFS* 2(1):7-41, 1996.

Cannon JG, Angel JB, Abad LW, Vannier E, Mileno MD, Fagioli L, Wolff SM, Komaroff AL. Interleukin-1 beta, interleukin-1 receptor antagonist, and soluble interleukin-1 receptor type II secretion in chronic fatigue syndrome. *Journal of Clinical Immunology* 17(3):253-61, 1997.

Sudaholnik RJ, Peterson DL, O'Brien K, Cheney PR et al. Biochemical evidence for a novel low molecular weight 2-5A-dependent RNase L in chronic fatigue syndrome. *J of Interferon & Cytokine research*. 17(7):377-85, 1997

III. A CHANGE IN NAME

The NCW recommends that the name of the syndrome be changed to chronic neuroendocrine-immune dysfunction syn-

drome, or CNDS. This recommendation is based on 1) the profile and frequency of the commonly reported symptoms of patients with chronic fatigue syndrome, 2) the chronicity of the illness and the lack of understanding of its cause(s) and, 3) the published evidence supporting an aberration or dysfunction of the neurological and immunologic systems. The name is in accordance with the principles outlined in Section II., above.

Changing the name to CNDS does and should not imply that the etiology or pathophysiology is understood. This name is broad enough to encompass the most commonly reported symptoms. It is quite reasonable to conclude that the commonly reported symptoms are associated with or referable to the neurologic, neuroendocrine, and immunologic systems. Finally the name explicitly states that the disorder is chronic.

IV. UTILIZATION OF CNDS

Advances in biomedical research may ultimately discover the pathophysiology or cause(s) of CNDS. Until the etiology is known, the name CNDS should be used for the reasons outlined above. The NCW anticipates that the biomedical community may find that subgroups or subtypes of CNDS may provide useful nosology (e.g., CNDS—orthostatic intolerant-predominant). Thus, the use of the name CNDS in conjunction with subgroup stratification offers flexibility and adaptability to the inevitable advances based on scientific research. This approach also promotes more accurate understanding of the illness when compared with the current name, chronic fatigue syndrome.

In the past there have been many efforts to categorize the syndrome based on a variety of criteria. Some of the more prominent of these potential subgroups have been used by scientists and patients, and will be reviewed below. The NCW does this in an effort to provide a conceptual framework for the name CNDS, and to better define the status of other names in use vis-à-vis our recommendations.

1) CFS: CFS is a term first introduced in 1988 in conjunction with the research case definition (Holmes, et al, 1988). It was maintained in the revision of the 1994 case definition (Fukuda et al., 1994). The 1994 definition is being used by researchers internationally and is in the

process of being revised by an international working group. A research case definition is designed to specifically define a research study population that excludes those potential study candidates who do not meet the criteria. The research case definition attempts to identify and categorize a homogeneous group of patients. However, some of the criteria are so restrictive that some patients who really do have the syndrome fail to meet the research case definition. Though the term CFS should refer to the research case definition, it has been used for all practical purposes to define all individuals with this condition. A research definition by its very nature should be used for research purposes only, not for clinical or diagnostic use in general practice. Scientists may continue to use the research case definition to identify homogenous groups of patients in order to compare the participants across different settings.

2) ME/CFS: A consensus panel in Canada has recently proposed a clinical case definition. The proposed criteria differ from and are broader than the Fukuda criteria for CFS. These criteria were developed specifically to be used in clinical practice.

3) ME: Myalgic encephalomyelitis (ME) is a condition first mentioned in the literature in the 1950s by Dr. Melvin Ramsey. It describes a condition similar to CFS. Myalgic means muscle pain and encephalo-myelitis means an acute inflammation of the brain and spinal cord. Some patient groups have endorsed the term myalgic encephalopathy, because the term encephalopathy does not necessarily require an inflammation in the central nervous system.

To be classified with ME according to the London criteria, patients are required to report the occurrence of post-exertional malaise, impairment of memory and concentration for a period of 6 months or longer, and a fluctuation or cycling in the severity of symptoms. Other groups subscribe to a description provided by Ramsey^{4, 5}.

4) Post-infectious fatigue syndrome, follows an infection or is associated with a current infection. According to the definition, individuals with this subtype should also fulfill the following additional criteria: definite evidence of infection at onset or presentation, presence of the syndrome for at least six

JOHN HERD'S RESPONSE TO THE NCW'S DRAFT

John Herd, a long-time CFIDS patient and advocate, offers a particularly articulate opinion.

The following are my personal opinions. Though I am a patient representative on the Name Change Workgroup, I have written these opinions as an individual patient activist, not as a voice of the NCW.

The patient community has suffered long enough with the name chronic fatigue syndrome.

Many doctors don't get it. They are not standing in our shoes and they don't experience all the incidents of being negatively judged because of the name. They don't see how we are shrugged off by doctors and referred to other doctors as if we are being told to go to hell.

It is not just doctors. There's a blight of misunderstanding throughout the public. The name is at least the fertilizer that allows it to grow.

A name change isn't going to eliminate all these problems, but it is a start. If the proposed Name Change NCW recommendations were to be adopted I suspect it would trigger discussions in the media and medical journals. These would be opportunities to get more accurate current information out there about the illness.

The formation of the NCW is the first real opportunity for the patient community to impact a potential name change. Let's not throw it away; it may be a long time before we have another opportunity.

Many patients from the international community want the U.S. government to adopt the name M.E. Despite this the health department and many doctors have long opposed universal adoption of the name M.E and particularly Myalgic encephalomyelitis. If I felt we could convince the U.S. government and the medical community to universally adopt the name M.E. I'd be behind the effort 100 percent. That's not the case though. I believe an all or nothing approach demanding the name M.E. would be throwing away our chances of getting a change.

Adopting a new name does not mean that the name M.E. won't continue to exist and be used. The NCW drafted its recommendations in the fashion it did so these dialogues and science can address these related issues as time proceeds. In the meantime let's get a better name than CFS.

I ask that every patient who supports the name Chronic Neuroendocrineimmune Dysfunction Syndrome (CNDS) fill out the questionnaire.

This is a time when the silent majority can't remain silent. If the NCW recommendations are going to have a chance they are going to need strong support from the patient community and from doctors.

We have to tell the government, doctors and organizations that by default if they don't support a change they are opposing it. As such they would be taking a hand in the continued harm to patients that the name is causing. Support doesn't mean a comment. I think we should expect them to take a proactive position on the name change because this is the time when their voices are needed.

Many have chosen to remain silent or keep a low profile about the name change issue—playing it safe. As an activist I ask that you discuss this matter with your doctors and organizations. Please try to get them to read the recommendations of the NCW, fill out the questionnaire, and get it in the hands of as many patients as possible. We need to give the message that playing it safe isn't safe any more. Maybe someone should start an online listing or tally board of doctor's and organization's public position about the name change recommendations—just a thought.

Now is a time for accountability and doing what's right for the patients.

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co-cure.org

Recommendations... continued from page 3

months after onset of infection, and corroboration of the infection by laboratory evidence.

V. CONCLUSION

The NCW urges the CFSCC to adopt the name CNDS. In conjunction with potential subgroup stratification, we believe the new name meets the current need for a more accurate label for the illness while allowing room for sub-grouping as biomedical advances take place.

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IN THE MIDDLE OF A
DIFFICULTY LIES
OPPORTUNITY.

—Albert Einstein (1879–1953)

LETTER FROM DR. RAINES ABOUT THE TESTING & TREATMENT FOR NEUROTOXINS

by Arthur L. Raines, M.D.

Dr. Arthur Raines met with almost 70 of our members on December 1, 2001. After an excellent presentation, he and his staff offered free testing to those present. (This was in response to the article on chronic neurotoxins in our last newsletter. Dr. Raines is the "local doctor" mentioned in the article.)

Due to scheduling constraints, this meeting was arranged on short notice and only those on our email list could be notified. If you wish to be added to this local email announcement list, contact Carol at lsieverl@flash.net. Dr. Raines has offices in Cleburne, Dallas and Ft. Worth. He can be reached at 817-645-3967.

Thank you for the opportunity to present the Shoemaker Protocol for Cholestyramine Binding therapy concept to your organization. Your members were well informed, assertive consumers of medical information who came up with some great questions.

Dr. Shoemaker has discovered neurotoxins which exist in several diseases including CFS/FM, sick building syndrome, Lyme disease among others (www.chronicneurotoxins.com). These neurotoxins are removed using an oral, non-absorbed prescription drug, cholestyramine, which is marketed to bind bile acids in the gut, and thereby reduce the blood cholesterol. A side effect of the cholestyramine is that it binds fat-soluble neurotoxins that get into the bile circulation. The bound neurotoxin/cholestyramine is eliminated in the stool.

Diagnosis depends on a medical history of exposures, symptoms and is facilitated by a Visual Contrast Sensitivity Test. During treatment with cholestyramine, some patients develop a short-term intensification of their symptoms called a Herxheimer reaction. This intensification can be blocked in some types of patients (but not CFS/FM patients) by pretreating with a prescription drug, pioglitazone.

Visual Contrast Sensitivity Testing is now understood to measure and reflect optic nerve blood flow that is influenced by neurotoxins as well as other factors such as glaucoma. The Visual Contrast Sensitivity Test is valuable as a tool to diagnose and to follow the progress of treatment in the patient by noting improvement on the Visual Contrast Sensitivity Testing. This improvement on the Visual Contrast Sensitivity Test tends to start as early as 36 hours after starting cholestyramine binding therapy, and may occur well before symptoms improve.

The results of the Visual Contrast Sensitivity Testing in your group are as follows: **Total tested: 67. Positive results: 27.** (Probability of successful treatment with CSM is 90% in this group.) **Borderline results: 8.** (Probability of successful treatment with CSM is 60% to 90%.) **Negative results: 32.** (Probability of successful treatment with CSM is 66% in this group.)

The above **approximate probability** numbers are based on research by Dr. Ritchie Shoemaker.

If you have at least 4 of the following 8 neurotoxic symptoms, I would recommend a trial of cholestyramine binding therapy, regardless of the outcome of the Visual Contrast Sensitivity Test: fatigue, headache, mental confusion, memory impairment, shortness of breath, abdominal pain, chronic muscle or joint pain, sensitivity to bright light.

The cost of the cholestyramine drug is somewhere in the range of \$120 per month, taking 4 doses per day. (Insurance may cover the cost.) Short-term treatment of 6 weeks to 3 months should give the patient and the doctor an idea of whether the therapy is working.

Prior to cholestyramine treatment, we prepare our patients with proper hydration, fiber for the diet, magnesium, liver factor support and antioxidants to facilitate the proper functioning of the bowel, liver and biliary system.

We got lots of questions about the Herxheimer reaction. I understand that no one wants to be miserable, but short-term misery would probably pay off with improved health. *If you are miserable, the therapy is working!* I will continue to communicate with the expert, Dr. Shoemaker, as I work with you all.

Dr. Shoemaker has identified a colonization with Staph bacteria in all of his CFS patients. Therefore, long term, we will need to try to change your gastrointestinal bacteria flora and your body chemistry, in order that you would not harbor this Staph bacteria which Dr. Shoemaker says is making a neurotoxin in your body. He also has some chronic Lyme disease patients who, after long courses of antibiotic treatment by other physicians, develop recurrences of symptoms similar to chronic Lyme or CFS/FM. These patients have, by culture, proven to have the Staph bacteria colonization and represent CFS/FM which has developed on top of a treated chronic Lyme disease. Repairing the patient's digestion, body bacterial flora and chemistry so they do not harbor the Staph bacteria, combined with cholestyramine binding therapy would appear to be the proper treatment for these patients.

I invite anyone who is interested in this therapeutic approach to make an appointment in one of our offices. We have already begun to treat one of your members. We will know the results in a few weeks.

The presentation was videotaped.

THE DFW LIGHTHOUSE CREDITS

Published quarterly, the *DFW Lighthouse* strives to inform its members and the public about a variety of topics relating to Chronic Fatigue Syndrome and Fibromyalgia. The CFS/FM Support Group of DFW is a clearinghouse for information about Chronic Fatigue Syndrome and Fibromyalgia. The Support Group does not endorse particular products or services, and the ideas expressed in the *DFW Lighthouse* are strictly those of the authors or quoted individuals. The CFS/FM Support Group of DFW, and the *DFW Lighthouse* assume no liability for any medical treatment or other activity undertaken by readers. For medical advice, consult your healthcare provider.

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CHENEY: MEMORANDUM ON MOLD EXPOSURE/TESTING

Exposure to mold toxin can be a significant hazard even to healthy individuals. This hazard can be even worse for CFS patients since their capacity to detoxify toxins, as well as their underlying immune activation (Th2 type), amplifies that hazard.

For those patients potentially exposed to mold, we recommend that you examine three or more rooms in which you spend the most time using special mold culture plates. These plates can be ordered from Prestige Publishing Company in Syracuse, NY for \$27.50 each, plus shipping. The plates are opened up to air about waist high in the center of the room for one hour and then closed up and shipped via the enclosed mailer back to Syracuse, New York. Results on mold exposure (expressed in colony numbers) will be returned to the patient in 10–12 weeks.

The number for ordering mold plates is 1-800-846-6687 (Prestige Publishing) which handles the books and other environmental recommendations of Dr. Sherry Rodgers, a physician and noted expert in environmental medicine.

TREATMENT FOR BACTERIA, FUNGUS & PARASITES

Cheney recommends the following to fight bacteria, fungus (including candida) and parasites. (A UCLA study documented that most CFS/FM patients had bacterial overgrowths in the small intestine that contribute to symptoms of fatigue, pain and “brain fog.”)



In a small amount of water combine the following liquid extracts:
Uva Ursi extract - 15 drops
Pau D’Arco extract - 15 drops
Wormwood (artemesia) / Black Walnut extract - 15 drops

Take on an empty stomach between meals, one month on then one month off. He recommends the brands Gaia or Eclectic Institute. All three extracts are available at a discount from needs.com. 1-800-634-1380

RAVE REVIEWS FOR CFS FILM

The award winning documentary on CFS, “I Remember Me”, premiered in New York on November 9th.

Strong attendance led to the film being held over for an additional week.

It recently opened in Chicago, where Roger Ebert began his review in the *Chicago Sun-Times* with the words, “I now believe in Chronic Fatigue Syndrome. I was one of many who somehow absorbed the notion that it was an imaginary illness. I am ashamed of myself.”

He goes on to say the film “does what the Centers for Disease Control in Atlanta shamefully failed to do: connects the dots.” The review can be read in its entirety in the archives at www.co-cure.org. It’s in week two of December in the “notice” section of the archives.

On December 12, Chicago’s CBS morning show will highlight clips from “I Remember Me” and interview renowned CFS researcher, Leonard Jason, Ph.D. The next day Spike

O’Dell, host of one of Chicago’s most popular morning-drive radio shows, will interview the film’s director and a CFIDS patient, Kim Snyder.

The film is scheduled for release on home video in late spring 2002. (See the website www.zeitgeistfilm.com) Under a special agreement with the distributor, a limited number of advance-copy videocassettes will be available to CFIDS Association of America members and supporters at a discounted price of \$25 (regular price \$39).

The association will take pre-orders between December 10 and December 21 only. To reserve your personal copy with your credit card, please call the Association’s Resource Line at 704-365-2343 or send an e-mail to mhanft@cfids.org. Your credit card will not be charged (\$25 plus \$1.95 shipping and handling) until the videotapes become available in February.

www.co-cure.org

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Meeting Information

The only meetings planned are those listed in this newsletter. Yoga classes are temporarily suspended for the summer months. Unless otherwise stated, we meet on the first (top) floor of the Edwards Cancer Center in the East Conference Room of Harris Methodist HEB Hospital in Bedford.

From Fort Worth, take the Central Drive exit off 183 and stay on the access road. From Dallas, take 183 (or 635 then 121 S to 183 W) to the Central Drive exit and do a U-turn under the freeway.

Sponsored by:



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