CHRONIC FATIGUE AND FIBROMYALGIA SYNDROMES MICHAEL C. SHARPE AND PATRICK G. OMALLEY pdf

1: Cognitive behavioral therapy - Wikipedia

The complexities of the chronic fatigue syndrome and the methodologic problems associated with its study indicate the need for a comprehensive, systematic, and integrated approach to the evaluation, classification, and study of persons with this condition and other fatiguing illnesses.

Yet PACE suffered from major flaws that have raised serious concerns about the validity, reliability and integrity of the findings. No PACE oversight committees appear to have approved the redefinition of recovery; at least, no such approvals were mentioned. Patients, advocates and some scientists quickly pointed out these and other problems. Yet the journal has taken no steps to address the issues. In December, an independent research group used that newly released data to calculate the recovery results per the original methodology outlined in the protocol. In the reanalysis, which appeared in the journal Fatigue: Moreover, in contrast to the findings reported in Psychological Medicine, the PACE interventions offered no statistically significant benefits. In conclusion, noted Wilshire et al. Besides the inflated recovery results reported in Psychological Medicine, the study suffered from a host of other problems, including the following: We know of no other studies in the clinical trial literature in which recovery thresholds for an indicator actually represented worse health status than the entry thresholds for serious disability on the same indicator. The participant testimonials and the newsletter article could have biased the responses of an unknown number of the two hundred or more people still undergoing assessmentsâ€”about a third of the total sample. It is irrelevant that insurance companies were not directly involved in the trial and insufficient that the investigators disclosed these links in their published research. Given this serious omission, the consent obtained from the trial participants is of questionable legitimacy. Such flaws are unacceptable in published research; they cannot be defended or explained away. The PACE investigators have repeatedly tried to address these concerns. Yet their efforts to dateâ€”in journal correspondence, news articles, blog posts, and most recently in their response to Wilshire et al. The PACE trial compounded these errors by using a case definition for the illness that required only one symptomâ€”six months of disabling, unexplained fatigue. A report from the U. National Institutes of Health recommended abandoning this single-symptom approach for identifying patients. Moreover, an unknown number of prospective participants might have met these alternate criteria but been excluded from the study by the initial screening. To protect patients from ineffective and possibly harmful treatments, White et al. Therefore, we are asking Psychological Medicine to retract the paper immediately. Patients and clinicians deserve and expect accurate and unbiased information on which to base their treatment decisions. We urge you to take action without further delay.

CHRONIC FATIGUE AND FIBROMYALGIA SYNDROMES MICHAEL C. SHARPE AND PATRICK G. OMALLEY pdf

2: Childhood chronic pain - Wikipedia

Chronic Fatigue and Fibromyalgia Syndromes Authors: Michael C. Sharpe & Patrick G. O'Malley Pages Editor: James L. Levenson, M.D. Date: August 6, and

Management[edit] Chronic pain can be treated in a number of ways, and varies depending on the type and severity of the condition. Common pain medications prescribed to children include paracetamol , ibuprofen , and acetylsalicylic acid. A meta-analysis by Christopher Eccleston and colleagues found that cognitive behavioural therapy CBT significantly reduced pain severity for children with chronic headaches. Research thus far has typically found small effects for improving psychological wellbeing, but more robust outcomes for pain relief. Children with severe disorders are particularly likely to miss school because of debilitating pain, as well as for medical appointments. High rates of school absence are associated with poor adjustment and psychosocial wellbeing among children with chronic illnesses. Inpatient education[edit] Some hospitals employ or contract tutors to assist children in inpatient care with their schoolwork. Hospital teachers are typically certified to teach a wide variety of ages and subjects. At the same time, in a study by Steinke et al. Additionally, many children with chronic pain have intermittent rather than extended absences, which makes them ineligible for homebound education services. Programs typically require a computer, Internet connection, a quiet and well-lit space, and parental supervision, demands that may prove burdensome for economically disadvantaged families. Such accommodations may include shorter school days, exemption from requirements like physical education classes, arrangements to deliver medication and other treatments, and programs to educate classmates about their disorder. These measures require extensive communication between teachers, doctors, and school nurses. Chronic pain is emotionally stressful both to the child affected and to his or her family, which may increase their risks for mental illness. Chronic pain, anxiety, depression, and PTSD are also all associated dysfunction involving serotonin and brain-derived neurotrophic factor. New research has also linked both chronic pain and mental illness to inflammation. Depression was also prevalent, and was correlated with functional disability. Many people do not typically associate chronic pain with children, and so may minimize or dismiss its impact. These two locations are more likely to be sources of chronic pain for girls, whereas boys are more likely to experience lower limb pain. Girls are also more likely than boys to experience multiple sources of pain. Young children often cannot describe their pain in ways that adults understand, and even older children may lack the vocabulary to clearly communicate with medical professionals. When children receive appropriate support from teachers and school counsellors, they are more likely to achieve attain success and psychological wellbeing. These children often face bullying and exclusion from peers, especially when they have visible markers of disability i.

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[et al.] -- Oncology / Mary Jane Massie and Donna B. Greenberg -- Rheumatology / Chris Dickens, James L. Levenson, and Wendy Cohen -- Chronic fatigue and fibromyalgia syndromes / Michael C. Sharpe and Patrick G. O'Malley -- Infectious diseases / James L. Levenson and Robert K. Schneider -- HIV/AIDS / NiccolÃ² D. Della Penna and Glenn J.

Chief, The Avery D. The authors have worked to ensure that all information in this book is accurate at the time of publication and consistent with general psychiatric and medical standards, and that information concerning drug dosages, schedules, and routes of administration is accurate at the time of publication and consistent with standards set by the U. Food and Drug Administration and the general medical community. As medical research and practice continue to advance, however, therapeutic standards may change. Moreover, specific situations may require a specific therapeutic response not included in this book. For these reasons and because human and mechanical errors sometimes occur, we recommend that readers follow the advice of physicians directly involved in their care or the care of a member of their family. Books published by American Psychiatric Publishing, Inc. Includes bibliographical references and index. Textbook of psychosomatic medicine. WM 90 A] RC Professor of Psychiatry and Behavioral Sciences Director of Medical Student Education in Psychiatry Emory University School of Medicine This book is dedicated to the memory of Alan Stoudemire â€" , a brilliant clinician, true scholar, prolific writer, and dedicated teacher and mentor. His contributions profoundly transformed our field. He was and remains an inspiration to others, in and outside our profession, for he lived life fully with passion and principle. He transcended his own illnesses with rare strength of spirit, deepening his compassion for and commitment to the medically ill, even while his own life was tragically abbreviated. Those of us who knew him well will forever miss his warmth, wit, and heartfelt friendship. This page intentionally left blank Contents Contributors. Factitious Disorders and Malingering. The text is neatly divided into sections, including general principles, symptoms and disorders, and different organ systems, which are reflected in the specialties and subspecialties of medicine. It concludes with a detailed discussion of the different treatments and management approaches. At the interface between psychiatry and other medical specialties, Psychosomatic Medicine is the newest psychiatric subspecialty recognized by the American Board of Medical Specialties. The American Board of Psychiatry and Neurology is developing the competencies and certification examination for this field, with the first examination to be held in June While research, clinical treatment, and teaching in Psychosomatic Medicine have been growing rapidly in the past decade, this field has evolved and matured over many years, with contributions from many great psychiatrists and other physicians such as Flanders Dunbar, Felix Deutsch, Franz Alexander, Harold Wolff, and Roy Grinker in the development of Psychosomatic Medicine in the first half of the twentieth century. In the s, the American Psychosomatic Society was founded, and the first issue of the journal Psychosomatic Medicine was published, followed in the s by the founding of the Academy of Psychosomatic Medicine and the first issue of Psychosomatics. Another growth spurt of Psychosomatic Medicine occurred in the s, with the appearance of a plethora of major texts, including those by Oscar Hill; Allister Munro; Wittkower and Warnes; Herbert Weiner; Lipowski, Lipsitt, and Whybrow; and a number of others. George Engel, an internist and psychoanalyst, brought psychiatry and medicine closer together and refocused the conceptual basis of the field through the biopsychosocial model. In the s and s, consultation-liaison psychiatry blossomed as the clinical application of psychosomatic principles over many years, with leaders such as Bish Lipowski, John Schwab, Tom Hackett, Jim Strain, Bob Pasnau, and Jimmie Holland. Today, Psychosomatic Medicine is a vibrant clinical field informed by a rapidly expanding research base, growing not only in North America and Europe but also in Japan, Australia, New Zealand, and many other nations. This fine work demonstrates the acceleration of advances in the field of Psychosomatic Medicine. The increasing complexity and subspecialization in the rest of medicine requires that the expert in Psychosomatic Medicine keep abreast of the latest advances in diagnosis and treatment in the other medical specialties. The contributors to this latest

and most advanced textbook of Psychosomatic Medicine are widely recognized experts who comprehensively cover all of the major psychiatric symptoms and disorders in the medically ill. For each major psychiatric disorder and each major medical disorder, they review epidemiology and risk factors; the effects of the psychiatric disorder on medical disorders and, conversely, the effects of medical diseases on the psyche; clinical features; diagnosis and assessment; differential diagnosis; management; and treatment. This textbook is very up-to-date, scholarly, and encyclopedic but also reflects an understanding that one must approach each patient as a unique, suffering individual. In this book, it refers to a specialized area of psychiatry whose practitioners have particular expertise in the diagnosis and treatment of psychiatric disorders and difficulties in complex medically ill patients Gitlin et al. We treat and study three general groups of patients: Psychosomatic Medicine practitioners work as hospital-based consultation-liaison psychiatrists Kornfeld , on medical-psychiatric inpatient units Kathol and Stoudemire , and in settings in which mental health services are integrated into primary care Unutzer et al. Psychosomatic Medicine is the newest psychiatric subspecialty formally approved by the American Board of Medical Specialties. There have been many other names for this specialized field, including consultation-liaison psychiatry, medical-surgical psychiatry, psychological medicine, and psychiatric care of the complex medically ill, among others. The first certifying examination is scheduled for June Psychosomatic Medicine has a rich history. The term psychosomatic was introduced by Johann Heinroth in , and Felix Deutsch introduced the term psychosomatic medicine around Lipsitt Psychoanalysts and psychophysiologists pioneered the study of mind-body interactions from very different vantage points, each contributing to the growth of Psychosomatic Medicine as a clinical and scholarly field. The National Institute of Mental Health made it a priority to foster the growth of consultationliaison psychiatry, through training grants circa and a research development program circa The Academy of Psychosomatic Medicine is the only U. The American Psychosomatic Society, an older cousin, is primarily devoted to psychosomatic research, and its members come from many disciplines Wise While consultation-liaison psychiatry and psychosomatic medicine flourished first in the United States, exciting work now comes from around the world. This is reflected in the membership of the Editorial Board and the contributors to this text, who include psychiatrists from the United States, Canada, United Kingdom, Australia, Spain, Italy, and Mexico. This book is organized into four sections. The first five chapters cover general principles in evaluation and management. Chapters 6â€”18 are devoted to psychiatric symptoms and disorders in the medically ill. Chapters 19â€” 36 address issues within each of the medical specialties and subspecialties. The final four chapters are summaries of psychiatric treatment in the medically ill. Psychosomatic Medicine has evolved, since its start, from a field based on clinical experience, conjecture, and theorizing into a discipline grounded in empirical research that is growing and spreading its findings into many areas of medical care Levenson APPI , whose faith in me and encouragement were inspirational. This book would not have been conceived if Psychosomatic Medicine had not become an official subspecialty of American psychiatry, and for that we all owe a great deal to Kostas Lyketsos, leader and comrade-in-arms in the long campaign, along with many others from the Academy of Psychosomatic Medicine who worked to make it a reality, including Dan Winstead, whose wise counsel has been invaluable. The value of this text comes from the untiring labors of the contributors, who were patient under repeated onslaughts of red ink from me. An assertive Editorial Board pushed us all toward the highest standards. Every chapter in this book has been critically reviewed by at least one member of the Editorial Board, and most have been externally reviewed as well. Chapters 19â€”36 have also been reviewed by one or more nonpsychiatric physician experts of the relevant specialty or subspecialty. Tina Coltri-Marshall provided invaluable service, keeping everyone organized and on schedule. Finally, this book would not have been possible without the most enthusiastic support from my chair, Joel Silverman; the help of my secretary, Pam Copeland; and the patience and tolerance of my family. Strategic integration of inpatient and outpatient medical-psychiatry services, in The American Psychiatric Publishing Textbook of Consultation-Liaison Psychiatry. Consultation-liaison psychiatry and the practice of medicine. Hackett Award lecture given at the 42nd annual meeting of the

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Academy of Psychosomatic Medicine, A historical and semantic inquiry. Consultation-liaison psychiatry and psychosomatic medicine: Collaborative care management of late-life depression in the primary care setting: A tale of two societies. Practitioners in this discipline assist with the care of a variety of patients, especially those with complex illnesses such as cancer, organ transplantation, and HIV infection Gitlin et al. In the medical setting, prompt recognition and evaluation of psychiatric problems are essential because psychiatric comorbidity often exacerbates the course of medical illness, causes significant distress in the patient, prolongs hospital length of stay, and increases costs of care. Psychiatrists in medical settings may be asked to evaluate a wide variety of conditions. These can include dementia, delirium, agitation, psychosis, substance abuse or withdrawal, somatoform disorders, personality disorders, and mood and anxiety disorders, as well as suicidal ideation, noncompliance, and aggressive and other behavioral problems. In addition, ethical and legal considerations are often critical elements of the psychiatric consultation. In this introductory chapter, we present a detailed approach to psychiatric assessment and consultation in a medical setting. Flexibility is essential for psychiatric consultants to be successful in the evaluation of affective, behavioral, and cognitive disturbances in medically ill patients. In the final section of the chapter, we briefly outline the benefits of psychiatric consultation for patients as well as for the greater hospital and medical communities. Psychiatric Consultation in the General Hospital Psychiatrists who work in medical settings are charged with providing expert consultation to medical and surgical patients. In many respects, psychiatric care of such patients is no different from the treatment of patients in a psychiatric clinic or in a private office. However, the constraints of the modern hospital environment demand a high degree of adaptability. Comfort, quiet, and privacy are scarce commodities in medical and surgical units. Interruptions by medical or nursing staff, visitors, and roommates erode the privacy that the psychiatrist usually expects. Patients who are sick, preoccupied with their physical condition, and in pain are ill-disposed to engage in the exploratory interviews that often typify psychiatric evaluations in other settings. Monitoring devices replace the plants, pictures, and other accoutrements of a typical office. Nightstands and tray tables are littered with medical paraphernalia commingled with personal effects. Additional visits for more history are often inevitable. Adapted from Lipowski Cooperation is enhanced if the psychiatrist sits down and operates at eye level with the patient. By offering to help the patient get comfortable e. When psychiatrists are consulted for unexplained physical symptoms or for pain management, it is useful to empathize with the distress that the patient is experiencing. This avoids conveying any judgment on the etiology of the pain except that the suffering is real. The Process of the Consultation Although it is rarely as straightforward as the following primer suggests, the process of psychiatric consultation should, in the end, include all the components explained below and summarized in Table 1â€”2. Speak Directly With the Referring Clinician Requests for psychiatric consultation are notorious for being vague and imprecise e. Review the current records and pertinent past records. Interview and examine the patient. Formulate diagnostic and therapeutic strategies. Speak directly with the referring clinician. They sometimes signify only that the team recognizes that a problem exists; such problems may range from an untreated psychiatric disorder to the experience of countertransferential feelings. In speaking with a member of the team that has requested the consultation, the consultant employs some of the same techniques that will be used later in examining the patient; that is, he or she listens to the implicit as well as the explicit messages from the other physician Murray Is the physician angry with the patient? Is the patient not doing what the team wants him or her to do?

CHRONIC FATIGUE AND FIBROMYALGIA SYNDROMES MICHAEL C. SHARPE AND PATRICK G. OMALLEY pdf

4: - NLM Catalog Result

BACKGROUND: Chronic fatigue syndrome (CFS) consists of a range of symptoms including fatigue, headaches, sleep disturbances, difficulties with concentration and muscle pain.

The Chronic Fatigue Syndrome: The complexities of the chronic fatigue syndrome and the methodologic problems associated with its study indicate the need for a comprehensive, systematic, and integrated approach to the evaluation, classification, and study of persons with this condition and other fatiguing illnesses. We propose a conceptual framework and a set of guidelines that provide such an approach. Our guidelines include recommendations for the clinical evaluation of fatigued persons, a revised case definition of the chronic fatigue syndrome, and a strategy for subgrouping fatigued persons in formal investigations. We have developed a conceptual framework and a set of research guidelines to use in studies of the chronic fatigue syndrome. The guidelines cover the clinical and laboratory evaluation of persons with unexplained fatigue; the identification of underlying conditions that may explain the presence of chronic fatigue; revised criteria for defining cases of the chronic fatigue syndrome; and a strategy for subdividing the chronic fatigue syndrome and other unexplained cases of chronic fatigue into subgroups. Background The chronic fatigue syndrome is a clinically defined condition characterized by severe disabling fatigue and a combination of symptoms that prominently features self-reported impairments in concentration and short-term memory, sleep disturbances, and musculoskeletal pain. Diagnosis of the chronic fatigue syndrome can be made only after alternate medical and psychiatric causes of chronic fatiguing illness have been excluded. No pathognomonic signs or diagnostic tests for this condition have been validated in scientific studies ; moreover, no definitive treatments exist for the chronic fatigue syndrome 8. Recent longitudinal studies suggest that some persons affected by the chronic fatigue syndrome improve with time but that most remain functionally impaired for several years 9, Issues in Chronic Fatigue Syndrome Research The central issue in chronic fatigue syndrome research is whether the chronic fatigue syndrome or any subset of it is a pathologically discrete entity, as opposed to a debilitating but nonspecific condition shared by many different entities. Resolution of this issue depends on whether clinical, epidemiologic, and pathophysiologic features convincingly distinguish the chronic fatigue syndrome from other illnesses. Clarification of the relation between the chronic fatigue syndrome and the neuropsychiatric syndromes is particularly important. The latter disorders are potentially the most important source of confounding in studies of the chronic fatigue syndrome. Somatoform disorders, anxiety disorders, major depression, and other symptomatically defined syndromes can manifest severe fatigue and multiple somatic and sychological symptoms and are diagnosed more frequently in populations affected by chronic fatigue and the chronic fatigue syndrome 14,15 than in the general population. The extent to which the features of the chronic fatigue syndrome are generic features of chronic fatigue and deconditioning due to physical inactivity common to a diverse group of illnesses 16,17 must also be established. In many persons with prolonged fatigue, fatigue persists beyond 6 months defined as chronic fatigue 21, We propose a conceptual framework Figure 1 to guide the development of studies relevant to the chronic fatigue syndrome. In this framework, in which the chronic fatigue syndrome is considered a subset of prolonged fatigue one month , epidemiologic studies of populations defined by prolonged or chronic fatigue can be used to search for illness patterns consistent with the chronic fatigue syndrome. Such studies, which differ from case-control and cohort studies based on predetermined criteria for the chronic fatigue syndrome, will also produce much-needed clinical and laboratory background information. This framework also clarifies the need to compare populations defined by the chronic fatigue syndrome with several other populations in case-control and cohort studies. The most important comparison populations are those defined by overlapping disorders, by prolonged fatigue, and by forms of chronic fatigue that do not meet criteria for the chronic fatigue syndrome. Controls drawn exclusively from healthy populations are inadequate to confirm the specificity of chronic fatigue syndrome-associated abnormalities. Need for Revised Criteria to Define the Chronic Fatigue Syndrome The possibility that chronic

fatigue syndrome study populations have been selected or defined in substantially different ways has made it difficult to interpret conflicting laboratory findings related to the chronic fatigue syndrome For example, the North American chronic fatigue syndrome working case definition 1 has been inconsistently applied by researchers This case definition is frequently modified in practice because some of the criteria are difficult to interpret or to comply with 25 and because opinions differ with regard to the classification of chronic fatigue cases preceded by a history of psychiatric illnesses 26, Current criteria for the chronic fatigue syndrome also do not appear to define a distinct group of cases 28, Reyes M, et al. For example, participants in the Centers for Disease Control and Prevention CDC chronic fatigue syndrome surveillance system 29 who met the chronic fatigue syndrome case definition did not substantially differ by demographic characteristics, symptoms, and other illness features from those who did not meet the definition except by criteria used to place patients into one of our predetermined surveillance classification categories [Reyes M, et al. These findings indicate that additional subgrouping or stratification of study cases into more homogeneous groups is necessary for comparative studies. Need for Clinical Evaluation Standards Our experience suggests that fatigued persons often receive inadequate or excessive medical evaluations. In the CDC chronic fatigue syndrome surveillance system, all participants were clinically evaluated by a primary physician before enrollment. These medical conditions were identified either from a single battery of routine laboratory tests done on blood specimens obtained at enrollment or from review of available medical records. We believe that inappropriate tests are often used to diagnose the chronic fatigue syndrome in chronically fatigued persons. This practice should be discouraged. Need for a Comprehensive and Integrated Approach The complexities of the chronic fatigue syndrome and the existence of several obstacles to our understanding of it make a comprehensive and integrated approach to the study of the chronic fatigue syndrome and similar illnesses desirable. The purpose of the proposed guidelines in Figure 2 is to facilitate such an approach. Definition and Clinical Evaluation of Prolonged Fatigue and Chronic Fatigue Prolonged fatigue is defined as self-reported, persistent fatigue of 1 month or longer. Chronic fatigue is defined as self-reported persistent or relapsing fatigue of 6 or more consecutive months. The presence of prolonged or chronic fatigue requires clinical evaluation to identify underlying or contributing conditions that require treatment. Further diagnosis or classification of chronic fatigue cases cannot be made without such an evaluation. The following areas should be included in the clinical evaluation. A thorough history that covers medical and psychosocial circumstances at the onset of fatigue; depression or other psychiatric disorders; episodes of medically unexplained symptoms; alcohol or other substance abuse; and current use of prescription and over-the-counter medications and food supplements. A mental status examination to identify abnormalities in mood, intellectual function, memory, and personality. Particular attention should be directed toward current symptoms of depressive or anxiety, self-destructive thoughts, and observable signs such as psychomotor retardation. Evidence of a psychiatric or neurologic disorder requires that an appropriate psychiatric, psychological, or neurologic evaluation be done. A thorough physical examination. A minimum battery of laboratory screening tests including complete blood count with leukocyte differential; erythrocyte sedimentation rate; serum levels of alanine aminotransferase, total protein, albumin, globulin, alkaline phosphatase, calcium, phosphorus, glucose, blood urea nitrogen, electrolytes, and creatinine; determination of thyroid-stimulating hormone; and urinalysis. Routinely doing screening tests for all patients has no known value 20, However, further tests may be indicated on an individual basis to confirm or exclude another diagnosis, such as multiple sclerosis. In these cases, additional tests or procedures should be obtained according to accepted clinical standards. The use of tests to diagnose the chronic fatigue syndrome rather than to exclude other diagnostic possibilities should be done only in the setting of protocol-based research. The fact that such tests are investigational and do not aid in diagnosis or management should be explained to the patient. In clinical practice, no additional tests, including laboratory tests or neuroimaging studies, can be recommended for the specific purpose of diagnosing the chronic fatigue syndrome. Tests should be directed toward confirming or excluding other etiologic possibilities. Examples of specific tests that do not confirm or exclude the diagnosis of the chronic

fatigue syndrome include serologic tests for Epstein-Barr virus, retroviruses, human herpesvirus 6, enteroviruses, and Candida albicans; tests of immunologic function, including cell population and function studies; and imaging studies, including magnetic resonance imaging scans and radionuclide scans such as single-photon emission computed tomography and positron emission tomography of the head. Conditions That Explain Chronic Fatigue The following conditions exclude a patient from the diagnosis of unexplained chronic fatigue. Any active medical condition that may explain the presence of chronic fatigue 31 , such as untreated hypothyroidism, sleep apnea and narcolepsy, and iatrogenic conditions such as side effects of medication. Any previously diagnosed medical condition whose resolution has not been documented beyond reasonable clinical doubt and whose continued activity may explain the chronic fatiguing illness. Such conditions may include previously treated malignancies and unresolved cases of hepatitis B or C virus infection. Any past or current diagnosis of a major depressive disorder with psychotic or melancholic features; bipolar affective disorders; schizophrenia of any subtype; delusional disorders of any subtype; dementias of any subtype; anorexia nervosa; or bulimia nervosa. Alcohol or other substance abuse within 2 years prior to the onset of the chronic fatigue and any time afterward. Any unexplained physical examination finding or laboratory or imaging test abnormality that strongly suggests the presence of an exclusionary condition must be resolved before further classification. Conditions That Do Not Adequately Explain Chronic Fatigue The following conditions do not exclude a patient from the diagnosis of unexplained chronic fatigue. Any condition defined primarily by symptoms that cannot be confirmed by diagnostic laboratory tests, including fibromyalgia, anxiety disorders, somatoform disorders, nonpsychotic or nonmelancholic depression, neurasthenia, and multiple chemical sensitivity disorder. Any condition under specific treatment sufficient to alleviate all symptoms related to that condition, and for which the adequacy of treatment has been documented. Such conditions include hypothyroidism for which the adequacy of replacement hormone has been verified by normal thyroid-stimulating hormone levels or asthma in which the adequacy of treatment has been determined by pulmonary function and other testing. Any condition, such as Lyme disease or syphilis, that was treated with definitive therapy before development of chronic symptomatic sequelae. Any isolated and unexplained physical examination finding, or laboratory or imaging test abnormality that is insufficient to strongly suggest the existence of an exclusionary condition. Such conditions include an elevated antinuclear antibody titer that is inadequate to strongly support a diagnosis of a discrete connective tissue disorder without other laboratory or clinical evidence. Back to Top Major Classification Categories: Chronic Fatigue Syndrome and Idiopathic Chronic Fatigue Clinically evaluated, unexplained chronic fatigue cases can be separated into either the chronic fatigue syndrome or idiopathic chronic fatigue on the basis of the following criteria. A case of the chronic fatigue syndrome is defined by the presence of the following: The method used for example, a predetermined checklist developed by the investigator or spontaneous reporting by the study participant to establish the presence of these and any other symptoms should be specified. A case of idiopathic chronic fatigue is defined as clinically evaluated, unexplained chronic fatigue that fails to meet criteria for the chronic fatigue syndrome. The reasons for failing to meet the criteria should be specified. Subgrouping and Stratification of Major Classification Categories In formal studies, cases of the chronic fatigue syndrome and idiopathic chronic fatigue should be subgrouped before analysis or stratified during analysis by the presence or absence of essential variables, which should be routinely established in all studies. Further subgrouping by optional parameters can be performed according to specific research interests. Essential Subgrouping Variables Any clinically important coexisting medical or neuropsychiatric condition that does not explain the chronic fatigue. Current level of fatigue, including subjective or performance aspects. These levels should be measured using published or widely available instruments. Examples include instruments by Schwartz and colleagues 37 , Piper and colleagues 38 , Krupp and colleagues 39 , Chalder and colleagues 40 , and Vercoulen and colleagues Total duration of fatigue. Current level of overall functional performance as measured by published or widely available instruments, such as the Medical Outcomes Study Short Form 36 42 and the Sickness Impact Profile Optional Subgrouping Variables Examples of optional variables include:

Epidemiologic or laboratory features of specific interest to researchers. Examples include laboratory documentation or self-reported history of an infectious illness at the onset of fatiguing illness, a history of rapid onset of illness, or the presence or level of a particular immunologic marker. Measurements of physical function quantified by means such as treadmill testing or motion-sensing devices. Back to Top Discussion Several general points must be appreciated if these guidelines are to be used as intended. First, the overall purpose of the proposed conceptual framework and guidelines is to foster a more systematic and comprehensive approach toward the collection of data about the chronic fatigue syndrome and similar illnesses. As such, these tools are intended for use as standard references. However, none of the components, including the revised case definition of the chronic fatigue syndrome, can be considered definitive. These research tools will evolve as new knowledge is gained. Second, none of the provisions in these guidelines, especially the definition of idiopathic chronic fatigue and subgroups of the chronic fatigue syndrome, establish new clinical entities. Rather, these definitions were designed to facilitate comparative studies. Finally, general reference to these guidelines should not be substituted for clear and detailed methodologic descriptions when reporting studies. The lack of detailed information about the sources, selection, and evaluation of study participants including controls , case definitions, and measurement techniques in reports of chronic fatigue syndrome research has contributed substantially to our current difficulties in interpreting research findings. Several specific points about the clinical evaluation are worth emphasizing. The primary purpose of clinically evaluating a person with unexplained fatigue is to identify and treat any underlying and contributing factors. Such an evaluation should begin, whenever possible, before 6 months has elapsed.

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5: Fatigue â€" Wikipedia Republished // WIKI 2

The revised case definition for the chronic fatigue syndrome is modeled on the chronic fatigue syndrome working case definition (1). The purpose of the revision was to address some of the.

R ; the PACE trial group: This article has been cited by other articles in PMC. Improvement may occur with medical care and additional therapies of pacing, cognitive behavioural therapy and graded exercise therapy. Although pacing has been advocated by patient organisations, it lacks empirical support. Specialist medical care is commonly provided but its efficacy when given alone is not established. This trial compares the efficacy of the additional therapies when added to specialist medical care against specialist medical care alone. The four treatments are standardised specialist medical care either given alone, or with adaptive pacing therapy or cognitive behaviour therapy or graded exercise therapy. Outcome will be assessed at 12, 24, and 52 weeks after randomisation. Two primary outcomes of self-rated fatigue and physical function will assess differential effects of each treatment on these measures. Secondary outcomes include adverse events and reactions, subjective measures of symptoms, mood, sleep and function and objective measures of physical activity, fitness, cost-effectiveness and cost-utility. The primary analysis will be based on intention to treat and will use logistic regression models to compare treatments. Secondary outcomes will be analysed by repeated measures analysis of variance with a linear mixed model. All analyses will allow for stratification factors. Mediators and moderators will be explored using multiple linear and logistic regression techniques with interactive terms, with the sample split into two to allow validation of the initial models. Economic analyses will incorporate sensitivity measures. Discussion The results of the trial will provide information about the benefits and adverse effects of these treatments, their cost-effectiveness and cost-utility, the process of clinical improvement and the predictors of efficacy. Background Introduction The chronic fatigue syndrome CFS is a condition characterised by chronic disabling fatigue and other symptoms, which are not better explained by an alternative diagnosis [1 - 3]. The prognosis is poor: There is now some evidence that specific treatments can improve these poor outcomes. However this positive statement was balanced in the report by other statements: The published trials of these treatments were however also criticized for being too small, too selective, and for using different outcome measures. CBT is a more complex therapy than GET, requiring highly trained therapists, and is therefore less readily available. In contrast, surveys carried out by Action for M. Pacing and rest were reported to be more helpful [13]. Pacing has been described in the scientific literature as a lifestyle management that allows optimal adaptation to the illness, including an appropriate balance of rest and activity [4 , 16]. A non-randomised comparison of adaptive rather than rehabilitative CBT, which included adaptive pacing therapy APT based on this model, found that, although fatigue improved, this treatment was no more effective than the control treatment in reducing disability [17]. A recent systematic review concluded that there was insufficient evidence to recommend APT at present [5 , 10 , 12]. In a similar way there is little RCT evidence of the efficacy of specialist medical care. There is therefore an urgent need to: Differential outcomes Because CBT and GET are both based on a graded exposure to activity, they may preferentially reduce disability, whilst APT, being based on the theory that one must stay within the limits of a finite amount of "energy", may reduce symptoms, but at the expense of not reducing disability. By measuring both symptoms and disability as our primary outcomes, we will be able to test a secondary hypothesis that these treatments may differentially affect symptoms and disability. Do illness beliefs or focusing of attention on symptoms symptom focusing need to be changed for CBT to be effective? Is increased physical fitness essential to recovery or not? How important is the alliance between therapist and patient? Is it necessary to adapt to the limitations imposed by the illness to reduce fatigue? A greater understanding of these processes will shed light on the essence of improvement and allow the development of more efficient treatments. Predictors of outcome Predictors of a negative response to treatment found in previous studies include having a mood disorder, membership of a self-help group, being in receipt of a disability pension, focusing on

physical symptoms, and pervasive inactivity [3 , 18 , 19]. There is however no general agreement on which are the most important predictive factors. Cost-effectiveness and cost utility A recent study has suggested that there is little difference in the cost-effectiveness of CBT and GET for chronic fatigue in primary care, and both were more expensive and more effective than standard care [20]. A further survey by Action for M. The individual treatment programmes used in PACE will minimise this risk by being mutually agreed between participant and therapist, carefully monitored and flexibly implemented. We will also carefully monitor all participants for any adverse effects of the treatments, and will undertake a detailed assessment, at home if necessary, of any participant who reports deterioration or who withdraws from treatment, following which they will be offered appropriate help. Rationale The results of this trial will: The trial will recruit new patients from secondary care clinics run by three different disciplines immunology, infectious disease and psychiatry in six different centres in both England and Scotland. This recruitment plan will ensure sufficient heterogeneity to allow generalisation of the findings. Furthermore, direct recruitment from primary care has been found to be problematic in previous studies. The secondary aims of this trial are to investigate the mechanisms and predictors of a successful outcome. Secondary objectives The secondary analyses are exploratory but we will be guided by previously published findings. Hypotheses of efficacy 1 APT is more effective than SSMC alone in reducing i fatigue, ii reducing physical disability and in reducing iii both.

CHRONIC FATIGUE AND FIBROMYALGIA SYNDROMES MICHAEL C. SHARPE AND PATRICK G. OMALLEY pdf

6: Chronic Fatigue Syndrome: Complete Text of Revised Case Definition - Prohealth

Causes of chronic fatigue syndrome includes hypotension, weakened immune system, hormonal imbalance, infections, or can be hereditary. Therapies can help treat. Once derided as yuppie disease, chronic fatigue syndrome is a real illness which affects every aspect of a person's life.

These findings are based on data of low quality. There was no clear difference between the groups, and, at present the meaning of this in day-to-day care is unclear. There was no clear difference between the groups. The meaning of this in day-to-day care is unclear. Older individuals in particular have certain characteristics that need to be acknowledged and the therapy altered to account for these differences thanks to age. Because smoking is often easily accessible, and quickly allows the user to feel good, it can take precedence over other coping strategies, and eventually work its way into everyday life during non-stressful events as well. CBT aims to target the function of the behavior, as it can vary between individuals, and works to inject other coping mechanisms in place of smoking. CBT also aims to support individuals suffering from strong cravings, which are a major reported reason for relapse during treatment. The results of random adult participants were tracked over the course of one year. During this program, some participants were provided medication, CBT, 24 hour phone support, or some combination of the three methods. Overall, the study concluded that emphasizing cognitive and behavioral strategies to support smoking cessation can help individuals build tools for long term smoking abstinence. It should be noted that individuals with a history of depressive disorders had a lower rate of success when using CBT alone to combat smoking addiction. CBT therapists also work with individuals to regulate strong emotions and thoughts that lead to dangerous compensatory behaviors. Cognitive behavioral therapy CBT has been suggested as the treatment of choice for Internet addiction, and addiction recovery in general has used CBT as part of treatment planning. Watson The modern roots of CBT can be traced to the development of behavior therapy in the early 20th century, the development of cognitive therapy in the s, and the subsequent merging of the two. Groundbreaking work of behaviorism began with John B. During the s and s, behavioral therapy became widely utilized by researchers in the United States, the United Kingdom, and South Africa, who were inspired by the behaviorist learning theory of Ivan Pavlov , John B. Watson , and Clark L. Skinner and his associates were beginning to have an impact with their work on operant conditioning. Beck was conducting free association sessions in his psychoanalytic practice. The therapeutic approaches of Albert Ellis and Aaron T. Beck gained popularity among behavior therapists, despite the earlier behaviorist rejection of " mentalistic " concepts like thoughts and cognitions. In initial studies, cognitive therapy was often contrasted with behavioral treatments to see which was most effective. During the s and s, cognitive and behavioral techniques were merged into cognitive behavioral therapy. Pivotal to this merging was the successful development of treatments for panic disorder by David M. Clark in the UK and David H. Barlow in the US. This blending of theoretical and technical foundations from both behavior and cognitive therapies constituted the "third wave" of CBT. This initial programme might be followed by some booster sessions, for instance after one month and three months. These are often met through " homework " assignments in which the patient and the therapist work together to craft an assignment to complete before the next session. It is also known as internet-delivered cognitive behavioral therapy or ICBT. CCBT has been found in meta-studies to be cost-effective and often cheaper than usual care, [] [] including for anxiety. CCBT is also predisposed to treating mood disorders amongst non-heterosexual populations, who may avoid face-to-face therapy from fear of stigma. However presently CCBT programs seldom cater to these populations. It has been proposed to use modern technology to create CCBT that simulates face-to-face therapy. This might be achieved in cognitive behavior therapy for a specific disorder using the comprehensive domain knowledge of CBT. This technique was first implemented and developed on soldiers overseas in active duty by David M. Rudd to prevent suicide.

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7: Fatigue - Wikipedia

M c L e a n S, C l a u w D J: Predicting chronic symptoms after an acute "stres sor" - les sons learn ed from 3 medical conditions. Med Hypotheses ,

We propose a conceptual debilitating but nonspecific condition shared by many dif- framework and a set of guidelines that provide such an ferent entities. Resolution of this issue depends on wheth- approach. Our guidelines include recommendations for er clinical, epidemiologic, and pathophysiologic features the clinical evaluation of fatigued persons, a revised convincingly distinguish the chronic fatigue syndrome case definition of the chronic fatigue syndrome, and a from other illnesses. The latter disorders are potentially the most important source of confounding in studies of Ann Intern Med. For current au- the general population. The extent to which the features of the chronic fatigue syndrome are generic features of chronic fatigue and de- conditioning due to physical inactivity common to a di- verse group of illnesses 16, 17 must also be established. We have developed a conceptual framework and a set of research guidelines for use in studies of the chronic A Conceptual Framework for Studying the Chronic fatigue syndrome. In many persons with prolonged fatigue, fatigue persists beyond 6 months defined as Background chronic fatigue 21, We propose a conceptual framework Figure 1 to The chronic fatigue syndrome is a clinically defined guide the development of studies relevant to the chronic condition characterized by severe disabling fatigue fatigue syndrome. Such studies, which differ from case- chronic fatiguing illness have been excluded. No patho- control and cohort studies based on predetermined crite- gnomonic signs or diagnostic tests for this condition have ria for the chronic fatigue syndrome, will also produce been validated in scientific studies ; moreover, no much-needed clinical and laboratory background informa- definitive treatments for it exist 8. These medical con- ditions were identified either from a single battery of routine laboratory tests done on blood specimens ob- tained at enrollment or from review of available medical records. We believe that inappropriate tests are often used to diagnose the chronic fatigue syndrome in chronically fa- tigued persons. This practice should be discouraged. Need for a Comprehensive and Integrated Approach The complexities of the chronic fatigue syndrome and the existence of several obstacles to our understanding of Figure 1. A conceptual framework of abnormally fatigued popu- it make a comprehensive and integrated approach to the lations, including those with the chronic fatigue syndrome CFS study of the chronic fatigue syndrome and similar illnesses and overlapping disorders. The purpose of the following proposed guide- lines Figure 2 is to facilitate such an approach. Controls drawn exclu- Chronic Fatigue Syndrome and Other Illnesses sively from healthy populations are inadequate to confirm Associated with Unexplained Chronic Fatigue the specificity of chronic fatigue syndrome-associated ab- normalities. Chronic fatigue is de- The possibility that chronic fatigue syndrome study fined as self-reported persistent or relapsing fatigue last- populations have been selected or defined in substantially ing 6 or more consecutive months. For example, the North American chronic conditions that require treatment. Further diagnosis or fatigue syndrome working case definition 1 has been classification of chronic fatigue cases cannot be made inconsistently applied by researchers This case def- without such an evaluation. The following items should be inition is frequently modified in practice because some of included in the clinical evaluation. A thorough history that covers medical and psycho- and because opinions differ about the classification of social circumstances at the onset of fatigue; depression or chronic fatigue cases preceded by a history of psychiatric other psychiatric disorders; episodes of medically unex- illnesses 26, Reyes M, et al. For example, partic- 2. A mental status examination to identify abnormali- ipants in the Centers for Disease Control and Prevention ties in mood, intellectual function, memory, and person- CDC chronic fatigue syndrome surveillance system 29 ality. Particular attention should be directed toward cur- who met the chronic fatigue syndrome case definition did rent symptoms of depression or anxiety, self-destructive not substantially differ by demographic characteristics, thoughts, and observable signs such as psychomotor re- symptoms, and other illness features from those who did tardation. Evidence of a psychiatric or neurologic

disorder not meet the definition except by criteria used to place requires that an appropriate psychiatric, psychological, or patients into one of our predetermined surveillance clas- neurologic evaluation be done. A thorough physical examination. These findings indicate that additional subgrouping or 4. A minimum battery of laboratory screening tests stratification of study cases into more homogeneous including complete blood count with leukocyte differen- groups is necessary for comparative studies. In the CDC chronic fatigue syndrome surveillance has no known value 20, However, further tests may system, all participants were clinically evaluated by a pri- be indicated on an individual basis to confirm or exclude mary physician before enrollment. Evaluation and classifica- tion of unexplained chronic fatigue. The use of tests to diagnose the chronic fatigue syn- The following conditions exclude a patient from the drome rather than to exclude other diagnostic possibili- diagnosis of unexplained chronic fatigue. Any active medical condition that may explain the research. The fact that such tests are investigational and presence of chronic fatigue 31 , such as untreated hypo- do not aid in diagnosis or management should be ex- thyroidism, sleep apnea, and narcolepsy, and iatrogenic plained to the patient. In clinical practice, no additional tests, including labo- 2. Any previously diagnosed medical condition whose ratory tests and neuroimaging studies, can be recom- resolution has not been documented beyond reasonable mended for the specific purpose of diagnosing the chronic clinical doubt and whose continued activity may explain fatigue syndrome. Tests should be directed toward con- the chronic fatiguing illness. Such conditions may include firming or excluding other etiologic possibilities. Examples previously treated malignancies and unresolved cases of of specific tests that do not confirm or exclude the diag- hepatitis B or C virus infection. Any past or current diagnosis of a major depressive tests for Epstein-Barr virus, retroviruses, human herpes- disorder with psychotic or melancholic features; bipolar virus 6, enteroviruses, and Candida albicans; tests of im- affective disorders; schizophrenia of any subtype; delu- munologic function, including cell population and func- sional disorders of any subtype; dementias of any subtype; tion studies; and imaging studies, including magnetic anorexia nervosa; or bulimia nervosa. Alcohol or other substance abuse within 2 years single-photon emission computed tomography and posi- before the onset of the chronic fatigue and at any time tron emission tomography of the head. The rea- sons for failing to meet the criteria should be specified. In formal studies, cases of the chronic fatigue syndrome 1. Any condition defined primarily by symptoms that and idiopathic chronic fatigue should be subgrouped be- cannot be confirmed by diagnostic laboratory tests, includ- fore analysis or stratified during analysis by the presence ing fibromyalgia, anxiety disorders, somatoform disorders, or absence of essential variables, which should be rou- nonpsychotic or nonmelancholic depression, neurasthenia, tinely established in all studies. Further subgrouping by and multiple chemical sensitivity disorder. Any condition under specific treatment sufficient to search interests. Essential Subgrouping Variables Such conditions include hypothyroidism for which the adequacy of replacement hormone has been verified by 1. Any clinically important coexisting medical or neu- normal thyroid-stimulating hormone levels or asthma in ropsychiatry condition that does not explain the chronic which the adequacy of treatment has been determined by fatigue. The presence or absence, classification, and tim- pulmonary function and other testing. Any condition, such as Lyme disease or syphilis, that tablished using published or freely available instruments, was treated with definitive therapy before development of such as the Composite International Diagnostic Instru- chronic symptomatic sequelae. Current level of fatigue, including subjective or per- sionary condition. Such conditions include an elevated formance aspects. These levels should be measured using antinuclear antibody titer that is inadequate to strongly published or widely available instruments. Examples in- support a diagnosis of a discrete connective tissue disor- clude instruments by Schwartz and colleagues 37 , Piper der without other laboratory or clinical evidence. Total duration of fatigue. Current level of overall functional performance as Syndrome and Idiopathic Chronic Fatigue measured by published or widely available instruments, Clinically evaluated, unexplained cases of chronic fa- such as the Medical Outcomes Study Short Form 36 42 tigue can be separated into either the chronic fatigue and the Sickness Impact Profile Optional Subgrouping Variables A case of the chronic fatigue syndrome is defined by the presence of the following: Epidemiologic or laboratory

features of specific in- new or definite onset has not been lifelong ; is not the terest to researchers. Examples include laboratory docu- result of ongoing exertion; is not substantially alleviated mentation or self-reported history of an infectious illness by rest; and results in substantial reduction in previous at the onset of fatiguing illness, a history of rapid onset of levels of occupational, educational, social, or personal illness, or the presence or level of a particular immuno- activities; and 2 the concurrent occurrence of four or logic marker. Measurements of physical function quantified by persisted or recurred during 6 or more consecutive means such as treadmill testing or motion-sensing devices. First, the overall lymph nodes; muscle pain, multijoint pain without joint purpose of the proposed conceptual framework and swelling or redness; headaches of a new type, pattern, or guidelines is to foster a more systematic and comprehen- severity; unrefreshing sleep; and postexertional malaise sive approach toward the collection of data about the lasting more than 24 hours. The revised case definition for the chronic fatigue syn- However, none of the components, including the revised drome is modeled on the chronic fatigue syndrome case definition of the chronic fatigue syndrome, can be working case definition 1. The purpose of our revisions considered definitive. These research tools will evolve as was to address some of the criticisms 25 of that case new knowledge is gained. Second, none of the provisions definition and to facilitate a more systematic collection of in these guidelines, especially the definition of idiopathic data internationally. We dropped all physical signs from chronic fatigue and subgroups of the chronic fatigue syn- our inclusion criteria because we agreed that their pres- drome, establish new clinical entities. Rather, these defi- ence had been unreliably documented in past studies. The nitions were designed to facilitate comparative studies. The lack of detailed increased the restrictiveness of the chronic fatigue information about the sources, selection, and evaluation syndrome working case definition without increasing the of study participants including controls , case definitions, homogeneity of cases Reyes M, et al. Disagreement occurred between those who Several specific points about the clinical evaluation are favored a more restrictive approach using several symp- worth emphasizing. The primary purpose of clinically tom criteria , as was done in the chronic fatigue evaluating a person with unexplained fatigue is to identify syndrome working case definition, and those who favored and treat any underlying and contributing factors. Such an a broader definition of chronic fatigue syndrome using evaluation should begin, whenever possible, before 6 fewer symptom criteria as was done in the Australian 3 months have elapsed. Because the particulars of any clin- and British 4 chronic fatigue syndrome case definitions. With regard to the clinical psychiatric evaluation Others argued that no symptoms have been shown to be of fatigued persons, we consider a mental status exami- specific for the chronic fatigue syndrome 28 and that nation to be the minimal acceptable level of assessment. Disagreement over this par- practical difficulties of implementing such a recommenda- ticular issue underscores the need to establish specific tion. Diagnosis of the chronic fatigue syndrome should features of the chronic fatigue syndrome and the validity not impede the treatment of coexisting disorders, notably of any chronic fatigue syndrome case definition. Developing an operational definition of fatigue was a Many conditions that are primary causes of chronic problem because the concept of fatigue itself is unclear fatigue preclude the diagnosis of the chronic fatigue syn- 45, In our conception of the chronic fatigue syn- drome or idiopathic chronic fatigue. We presented prin- drome, the symptom of fatigue refers to severe mental ciples for identifying such exclusionary conditions rather and physical exhaustion, which differs from somnolence or than listing them because of the range and complexity of lack of motivation and which is not attributable to exer- human illnesses. In some instances, however, we identified tion or diagnosable disease. We retained the requirement specific exclusionary conditions. The such as fatigue or joint pains, extremely difficult. It is difficult to interpret symptoms typical of the to verify. More im- tigue" to focus attention on the need to clarify how other portantly, care of these persons should focus on their forms of unexplained chronic fatigue are related to the chronic psychiatric disorder. On the other hand, we did chronic fatigue syndrome. Such psychiatric conditions are highly prevalent evaluations of patients with chronic fatigue. Subgrouping in persons with chronic fatigue and the chronic fatigue by essential variables will encourage the collection of a syndrome, and the exclusion of persons with these condi- body of core data. Additional subgrouping by

optional tions would substantially hinder efforts to clarify the role variables will allow researchers considerable flexibility in that psychiatric disorders have in fatiguing illnesses. This defining specific subgroups to answer specific research is a particularly important issue to resolve. These parts of questions. We sympathize with those who fatigue cases preceded by some, but not all, psychiatric are concerned that this name may trivialize this illness. We support changing the 2. What is myalgic en- name when more is known about the underlying patho- cephalomyelitis? Preva- physiologic process or processes associated with the lence of chronic fatigue syndrome in an Australian population. Med J chronic fatigue syndrome and chronic fatigue.

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Chapter 10 the americans Man and the Earth. Encyclical Laborem exercens Regular and irregular plural nouns list Transformations (Books of Magic, Vol. 4) Chronology of Twentieth Century History Ethnic internal migration in England and Wales : spatial analysis using a district classification framewo Label a clock 2nd grade The Death of Sigmund Freud Financial and legal issues facing the United Mine Workers of America Combined Benefit Fund The Preacher And The People Accounting and business management The use of cleaner production technologies in metal finishing and electronics industries Hidden bodycount, unseen victims The technological solution: from the west report to Regis University The Thompson Chain Reference Bible Malayalam shows blank in windows 7 pc The Sleepytime Ponies Trick a Trickster Paraguay in pictures Formal operations measure The History and Antiquities of the Anglo-Saxon Church Gefran agl 50 manual Save picture as Must an education have an aim? By R. S. Peters. The Middle Eastern Economy Dialogue I. Between General Wolfe, General Montgomery, and David Hume African native music How To Raise A Gentleman A Civilized Guide To Helping Your Son Through His Uncivilized Childhood A General History of Earthquake Studies in China Gods wonderful railway The religious vampire: reason, romantics, and Victorians Encyclopedia of geology internet archive Vietnam travel guide Language, meaning, and context My Sheep Know My Voice Preventing/minimizing stress Proof of psychic abilities in humans and animals Types of pneumatic valves and their applications 1. Ancient Wisdom in a Changing World 15 How the system worked