

## Appendix B: Summary of evidence highlighted to NICE during consultation

Of the approximately 300 pieces of evidence highlighted to NICE by stakeholders during the consultation, the following 13 met criteria to be included in the surveillance review. Any potential impact on the guideline of the evidence is also noted.

Reference	Theme	Impact on guideline (Potential impact; Unclear Impact; No impact)
<a href="#">Chronic fatigue syndrome prevalence is grossly overestimated using Oxford criteria compared to Centers for Disease Control (Fukuda) criteria in a U.S. population study</a> (Baraniuk 2017)	Diagnosis	Potential – Adds to criticism of Oxford criteria which was used by some studies the guideline is based on.
<a href="#">Implementing resources to support the diagnosis and management of Chronic Fatigue Syndrome/Myalgic Encephalomyelitis (CFS/ME) in primary care: A qualitative study</a> (Bayliss 2017)	Diagnosis	Potential – Barriers to the implementation of training and resources for CFS/ME in primary care remain, and there is a need to support CFS/ME patients to access reliable, evidence based information outside primary care.
<a href="#">A comparison of health status in patients meeting alternative definitions for chronic fatigue syndrome/myalgic encephalomyelitis</a> (Johnston 2014)	Diagnosis	Potential – Patients identified by the International Consensus Criteria (ICC) have more severe impairment to their physical and social functioning than patients complying with the 1994 Centers for Disease Control and Prevention (CDC). The ICC identifies a distinct subgroup found within patients complying with the 1994 CDC definition.
<a href="#">The Newcastle NHS Chronic Fatigue Syndrome Service: not all fatigue is the same</a> (Newton 2010)	Diagnosis	Potential – 40% of people referred to a specialist ME/CFS service in Newcastle did not have a diagnosis of ME/CFS on further assessment.

<p><a href="#">Neurohumoral and haemodynamic profile in postural tachycardia and chronic fatigue syndromes</a> (Okamoto 2012)</p>	<p>Diagnosis</p>	<p>Potential – Fatigue and CFS-defining symptoms are common in patients with postural tachycardia syndrome (POTS). The majority of them met criteria for CFS.</p>
<p><a href="#">Clinical characteristics of a novel subgroup of chronic fatigue syndrome patients with postural orthostatic tachycardia syndrome</a> (Lewis 2013)</p>	<p>Diagnosis</p>	<p>Potential – The presence of POTS marks a distinct clinical group of CFS patents, with phenotypic features differentiating them from those without POTS. A combination of validated clinical assessment tools can determine which CFS patients have POTS with a high degree of accuracy, and thus potentially identify those who require further investigation and consideration for therapy to control heart rate.</p>
<p><a href="#">Guided graded exercise self-help plus specialist medical care versus specialist medical care alone for chronic fatigue syndrome (GETSET): A pragmatic randomised controlled trial</a> (Clark 2017)</p>	<p>Treatment</p>	<p>Unclear – The abstract on face value agrees with the guideline recommendation for graded exercise therapy (GET; ‘graded exercise is a safe intervention that might reduce fatigue and, to a lesser extent, physical disability for patients with chronic fatigue syndrome’). However papers such as <a href="#">Davenport 2017</a> have critiqued the evidence in this trial and called into question the validity of results.</p>
<p><a href="#">M.E. Time to deliver. Initial findings of Action for M.E.’s 2014 survey</a></p>	<p>Treatment</p>	<p>Potential – 85% found pacing helpful, 12% found it made no change and 4% said their condition got worse (cf. 54%, 34%, and 12% for cognitive behavioural therapy [CBT] and 48%, 19%, and 24% for GET respectively). Patients’ value of treatments may not align with guideline recommendations.</p>
<p><a href="#">Close to collapse. An interim report on access to social care and advocacy for people with M.E./CFS</a> (Action for ME 2015)</p>	<p>Treatment</p>	<p>Potential – 97% of respondents experienced 2 or more difficulties with daily living activities listed in the Care Act 2014 for England. However, just 16% had received social care</p>

		assessments. Of these, only 6% had been awarded a care package.
<a href="#">Specialist treatment of chronic fatigue syndrome/ME: a cohort study among adult patients in England</a> (Collin 2017)	Treatment	No – An evaluation of specialist services country-wide following current NICE guidelines on assessment and treatment, showing significant benefit for around a third of patients a year after treatment.
<a href="#">Cytokine Inhibition in Patients With Chronic Fatigue Syndrome: A Randomized Trial</a> (Roerink 2017)	Treatment	No – Peripheral IL-1 inhibition using anakinra for 4 weeks does not result in a clinically significant reduction in fatigue severity in women with CFS and severe fatigue.
<a href="#">ME/CFS patients' reports of symptom changes following CBT, GET and Pacing Treatments: Analysis of a primary survey compared with secondary surveys</a> (Geraghty 2017)	Treatment	Potential – Analysed data from a large cross-sectional patient survey (n=1,428) and compared findings with comparable patient surveys (n=16,665). CBT is of benefit to a small percentage of patients (8–35%); GET brings about large negative responses in patients (54–74%); while pacing is the most favoured treatment with the lowest negative response rate and the highest reported benefit (44–82%).
<a href="#">Economic evaluation of multidisciplinary rehabilitation treatment versus cognitive behavioural therapy for patients with chronic fatigue syndrome: A randomized controlled trial</a> (Vos-Vromans 2017)	Treatment	Unclear – Multidisciplinary rehabilitation treatment (i.e. gradual reactivation, pacing, mindfulness, body awareness therapy, normalising sleep-wake rhythm and social reintegration combined with CBT) was more cost-effective than CBT when using fatigue as primary outcome variable. Using QALY as the primary outcome, CBT was more cost-effective.