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VA/DoD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF CHRONIC MULTISYMPTOM ILLNESS

Department of Veterans Affairs

Department of Defense

Pocket Card

QUALIFYING STATEMENTS

The Department of Veterans Affairs and the Department of Defense guidelines are based upon the best information available at the time of publication. They are designed to provide information and assist decision-making. They are not intended to define a standard of care and should not be construed as one. Neither should they be interpreted as prescribing an exclusive course of management.

This Clinical Practice Guideline is based on a systematic review of both clinical and epidemiological evidence. Developed by a panel of multidisciplinary experts, it provides a clear explanation of the logical relationships between various care options and health outcomes while rating both the quality of the evidence and the strength of the recommendations.

Variations in practice will inevitably and appropriately occur when clinicians take into account the needs of individual patients, available resources, and limitations unique to an institution or type of practice. Every healthcare professional making use of these guidelines is responsible for evaluating the appropriateness of applying them in the setting of any particular clinical situation.

These guidelines are not intended to represent TRICARE policy. Further, inclusion of recommendations for specific testing and/or therapeutic interventions within these guidelines does not guarantee coverage of civilian sector care. Additional information on current TRICARE benefits may be found at www.tricare.mil or by contacting your regional TRICARE Managed Care Support Contractor.

Working Definition of Chronic Multisymptom Illness

- Chronic multisymptom illness (CMI) is a label given to a diverse set of disorders including, but not limited to, chronic fatigue syndrome (CFS), fibromyalgia syndrome (FMS), and irritable bowel syndrome (IBS).
- CMI encompasses military-specific medically unexplained illnesses, such as Gulf War Illness, Gulf War Syndrome, or post-deployment syndrome.
- The definition of CMI also includes patients without accepted labels, defined by generally accepted criteria, who exhibit persistent or frequently recurring symptoms negatively impacting daily function for a minimum of six months duration from two or more of the following six categories:
    - Fatigue
    - Mood and cognition
    - Musculoskeletal (including pain)
    - Respiratory
    - Gastrointestinal
    - Neurologic (including headache).

Patients with symptoms lasting less than six months, or who experience only one of the listed symptoms, or with a clearly organic-based disease that explains all/most of their symptoms were not covered in this report. Further consideration for inclusion should be given to symptoms affecting the following systems: genitourinary, cardiopulmonary, and sleep.

Diagnosis and Evaluation

CMI Symptom Attributes

- Duration
- Onset
- Location
- Co-morbidity
- Previous Episodes
- Intensity and impact
- Previous treatment and medications
- Past medical, surgical, and psychological history
- Patient perception of symptoms

Risk Factors for CMI

Strong Strength of Directness/Generalizability

- Older age (born before 1960)
- Female
- Army vs. Air Force (Limited to OIF/OEF)
- Reserve guard members (Limited to OIF/OEF)
- Officers (Limited to OIF/OEF) – negative association
- History of smoking (Both in Desert Storm and Desert Shield and OEF/OIF)
- Alcohol abuse (Limited to OIF/OEF)
- More education to reduce misinterpretation (Limited to OIF/OEF)
- Mental health problem, anxiety, depression, PTSD (Limited to OIF/OEF)
- History of depression and anxiety (pre-war) (Limited to Desert Storm and Desert Shield)
- Higher combat exposure (Limited to Desert Storm and Desert Shield)
- Gulf War deployment
- Khamsiyah exposure (Limited to Desert Storm and Desert Shield)

Moderate Strength of Directness/Generalizability

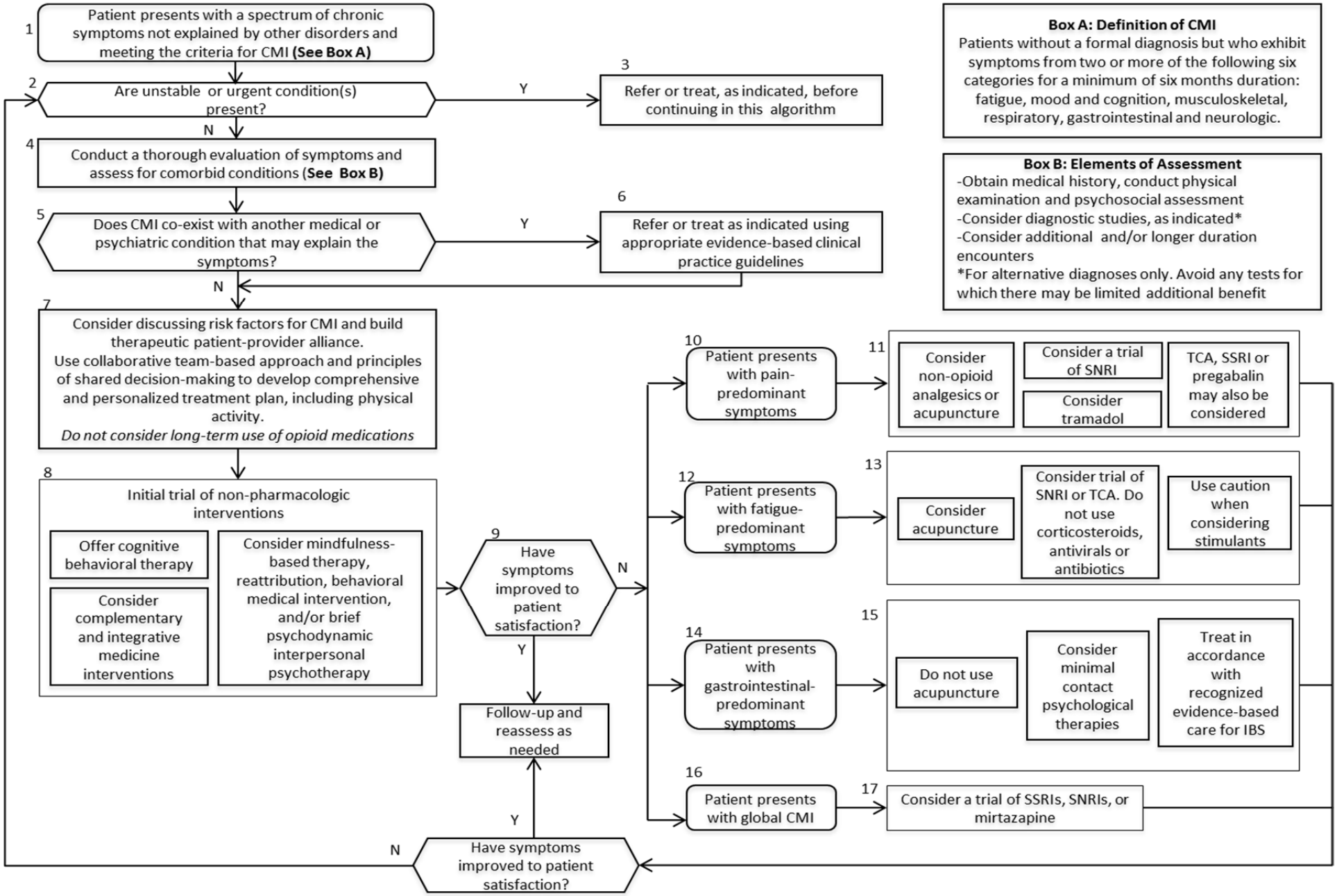
History of sexual abuse (all forms) (Indirect for CMI but consistent across symptom based syndromes)
History of sexual abuse (rape) (Indirect for CMI but consistent across symptom based syndromes)

Pharmacotherapies for Chronic Multisymptom Illness

- Refer to CPG and algorithm for relative usage and timing of therapies
- Refer to current Product Information for additional prescribing information.

Agent	Predominant Symptom
Escitalopram	Global
Fluoxetine	Global* Pain
Sertraline	Global*
Venlafaxine	Global*
Venlafaxine Extended-release	Global*
Mirtazapine	Global*
Duloxetine	Pain Fatigue
Milnacipran	Pain Fatigue
Amitriptyline	Pain Fatigue
Pregabalin	Pain
Paroxetine controlled release	Pain
Citalopram	Pain

Algorithm – Panels 3 and 4



Recommendations

Please refer to the clinical practice guideline and summary document for full text of recommendations

Recommendation
Diagnosis and Evaluation
1. All patients should receive a thorough evaluation of symptoms based on clinical judgment. *Strong For*
2. Do not use any test for which there may be limited additional benefit to confirm the diagnosis of CMI. Testing for rare exposures or biologic effects should only be done in the presence of supportive history or physical findings. *Strong Against*
3. Discuss risk factors using principles of health risk communication within a therapeutic patient-provider alliance for those patients who wish to further understand factors that could contribute to their condition. *Weak For*
Management Strategies
4. Use a collaborative, team-based approach, including a behavioral health specialist, for the primary care management of patients with CMI. *Strong For*
5. Use shared-decision making principles to develop a comprehensive and personalized treatment plan in the care and management of patients with CMI. *Strong For*
6. All providers involved in the care of patients with CMI are encouraged to enhance their knowledge of the following critical domains: a. Communication skills (e.g., active listening, risk communication/perception) b. Empathy skills c. Working with interdisciplinary teams d. The biopsychosocial model e. Risk factors for CMI and analogous conditions f. Military cultural competency g. Deployment related exposures *Weak For*
Therapeutic Interventions for Global CMI
7. Incorporate appropriate elements of physical activity as part of a comprehensive and integrated treatment plan. *Strong For*
8. Offer cognitive behavioral therapy, delivered by trained professionals. *Strong For*
9. Consider mindfulness-based therapy, reattribution, behavioral medical intervention, and/or brief psychodynamic interpersonal psychotherapy, delivered by trained professionals. *Weak For*
10. Consider complementary and integrated medicine interventions as a component of personalized, proactive patient-driven care. *Weak For*
11. Consider a trial of selective serotonin reuptake inhibitor (SSRI), serotonin–norepinephrine reuptake inhibitor (SNRI), or mirtazapine. *Weak For*
12. Consider not using doxycycline. *Weak Against*
13. Do not use long-term opioid medications. *Strong Against*
Therapeutic Interventions for Pain-Predominant CMI
14. Consider acupuncture. *Weak For*
15. Consider non-steroidal anti-inflammatory drugs (NSAID) for treating certain peripheral pain symptoms associated with CMI, though they do not necessarily lead to global beneficial effect. *Weak For*

Recommendation
16. Consider tramadol for treating certain pain symptoms associated with CMI that fail to respond to other non-opioid analgesic medications or non-pharmacologic approaches. *Weak For*
17. Consider a trial of serotonin–norepinephrine reuptake inhibitor (SNRI) for the treatment of patients with clinical symptoms of pain-predominant CMI. *Weak For*
18. Consider a trial of tricyclic antidepressants (TCA), selective serotonin reuptake inhibitor (SSRI), or pregabalin (PGB) for the treatment of patients with clinical symptoms of pain-predominant CMI. *Weak For*
Therapeutic Interventions for Fatigue-Predominant CMI
19. Considering acupuncture as part of the management of patients with fatigue-predominant symptoms of CMI. *Weak For*
20. Consider a trial of SNRI or tricyclic antidepressants (TCA) for patients with clinical symptoms of fatigue-predominant CMI. *Weak For*
21. Consider not using pharmacologic agents for sleep disturbances in CMI. *Weak Against*
22. Consider not using stimulants for the treatment of fatigue-predominant CMI. *Weak Against*
23. Do not use antivirals or antibiotics for the treatment of fatigue-predominant CMI. *Strong Against*
24. Do not use corticosteroids for the treatment of fatigue-predominant CMI. *Strong Against*
25. Do not use immunotherapies for the treatment of the symptoms of fatigue-predominant CMI. *Strong Against*
Therapeutic Interventions for Gastrointestinal-Predominant CMI
26. Consider treating predominantly gastrointestinal symptoms in accordance with recognized evidence-based care for IBS. *Weak For*
27. Consider minimal contact psychological therapies for treatment of gastrointestinal-predominant CMI. *Weak For*
28. Consider not using acupuncture for treatment of patients with gastrointestinal-predominant symptoms of CMI. *Weak Against*