

Important notice: Please note that the information on Treatment provided here has been compiled **by patients for patients**, and represents a summary of what patients may have experienced in working with their individual health care providers. The information in this website is not a substitute for professional medical advice. Please consult with your physician or other healthcare provider in matters pertaining to your medical care. See our full [Disclaimer](#) .

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It is important to take extra steps to avoid medication interactions or errors, like being sure that the risks and benefits, side effects and proper use of medications are reviewed and understood by the patient before leaving the visit. All doctors and healthcare providers should be told which medications and supplements are being used, in order to prevent interactions. One serious and potentially life-threatening interaction is called, Serotonin Syndrome, which can happen if too many products are combined that increase serotonin levels. Some foods and beverages can affect how some medications work, so medications should usually be taken with water (unless otherwise instructed). And when picking up prescriptions from the pharmacy, it is a good idea to double-check them while at the counter to see if they are the right medication and in the right amount

Sleep Disorder

Inability to fall asleep, stay asleep and/or experiencing other disruptions during sleep are just a few of the types of sleep problems experienced by patients with the Chronic Fatigue Syndrome/Chronic Fatigue and Immune Dysfunction Syndrome/Myalgic Encephalopathy (CFS/CFIDS/ME), and Fibromyalgia (FM). One of the most serious disruptions that warrants sleep study and special intervention is sleep apnea. Periodic limb movement, unusual sensations, and/or restless legs syndrome (RLS) are other problems that can disrupt sleep and are treated with specific medications that affect dopamine release. Due to the complexity of these distinct disorders, they are not included under general sleep aids and medications.

Some simple things that patients can try on their own (or with the help of a sleep specialist) are to develop good sleep hygiene habits—like avoiding caffeine late in the day, going to bed and getting up around the same time each day, keeping the room comfortably cool, and using the bed primarily for sleep. Some find having a small snack of bananas, warm milk, oatmeal or whole-wheat toast with a little honey will help to relax them for sleep because of the tryptophan or other soothing brain chemicals that are released by these foods. There are several herbal products that can be used to help with sleep and relaxation—please refer to our Supplements section.

Several over the counter products, like Benadryl (diphenhydramine hydrochloride) or Unisom (doxylamine) are occasionally used because as antihistamines that cross the blood/brain barrier, they tend to make people drowsy/sleepy. These are found to be more effective for occasional use rather than long-term use because sedating effects will start to decrease. The most common treatments to help with sleep will be medications (often more than one) that help to initiate sleep and promote deeper sleep (stages 3 and 4). There are four primary groups of medications which are used for their specific effects, such as:

- Antidepressants—often the first line of treatment prescribed will be one of tricyclic antidepressants and a few examples of these are Elavil (amitriptyline), Norpramin (desipramine), and Sinequan (doxepin). The latter is often prescribed in liquid form at a very low dose (only a few drops) along with another medication. As the primary sleep medication starts to wear off, doxepin helps to keep patients asleep longer mainly by its ability to block histamine. Another group of antidepressants, classified as 5-HT receptor antagonists, may also be prescribed, like Desyrel (trazodone) or Remeron (mirtazapine). These belong to the triptans, a family of medications that include migraine treatments. Generally, antidepressants are used to take advantage of certain neurochemical changes they can provide to help with sleep (aside from how they work for depression). Dosage for sleep is usually lower than for treatment of depression. Due to a frequent lower threshold of dosage tolerance, physicians may start a prescription at a lower dosage in order to find the right level to induce sleep.

- Benzodiazepines—these are central nervous system suppressants and are used for their overall sedating or muscle relaxing properties and may include Xanax (alprazolam), Ativan (lorazepam) and Valium (diazepam). Klonopin (clonazepam) is one of the more frequently prescribed medications from this group because it also has anticonvulsant properties. Klonopin works by balancing the firing of certain neurons and thereby, helping to reduce sensory overload. It also has been found to relieve myoclonus (sudden jerking while sleeping) in many patients. If or when it needs to be discontinued, this should be done slowly by tapering the dose down over several weeks (or as determined by prescribing physician).

- Non-benzodiazepine agents—these are the newer formulations which are described as shorter-acting hypnotic sleep aids and some of these are Ambien (zolpidem), Sonata (zaleplon),

and Lunesta (eszopiclone). Though these are promoted as medications that can be taken with less concern about duration of use or dependence, some can still cause very unusual side effects. One in particular has been Ambien which has been found to cause sleep-walking and amnesia in some individuals.

- Muscle relaxants—this line of medication may be prescribed for night-time use, as these are usually quite sedating and can provide some level of pain relief. A few of the most commonly used products are Flexeril (cyclobenzaprine) and Soma (carisprodol).

- Xyrem (a sleep agent derived from gamma-hydroxybutyrate (GHB) and already used in treatment of daytime sleepiness in narcolepsy) is occasionally prescribed for sleep. It is a very potent/aggressive type of sleep agent and one must work with a doctor who has good knowledge and experience with it. It is currently being studied for FM pain and daytime symptoms.

Pain

Pain is a major symptom in both FM and CFS/CFIDS/ME, although many don't initially think of CFS/CFIDS/ME as illnesses with pain. Since patients experience many types of pain—such as muscle aches and spasms, fatigue pain in muscles from lactic acid build-up, myofascial pain, multiple joint pain, neuropathy, and headaches, including migraines—therefore, pain is often treated with a combination of medications and/or therapies.

Many patients find they have a hard time getting adequate treatment of their pain and are often met with resistance by their doctors—in particular, primary care physicians. This is often due to not understanding how to use certain medications, misconceptions about dependence versus addiction and/or efforts to avoid scrutiny by regulatory agencies. It may become necessary for patients to seek out doctors who specialize in treating pain, possibly rheumatologists or physiatrists (specialists in physical medicine and rehabilitation) and/or pain management. There are clinics/centers dedicated to pain management which operate as small private practices or as pain management clinics within hospitals.

Home remedies can include use of ice or heat packs. Ice packs help to reduce swelling and slow down the nerve impulses to a localized area of pain, while heat packs help to increase blood flow to a localized area of pain and ease stiffness. The most commonly prescribed treatments are listed below, while it is understood many other medications/ protocols are being used.

- Over the Counter (OTC) pain relievers—Tylenol (an analgesic using acetaminophen as its active ingredient), Motrin or Advil (nonsteroidal anti-inflammatories that use ibuprofen, as an active ingredient, to reduce pain and inflammation), and/or Aspirin (from a group of drugs called salicylates) which is used to relieve pain and inflammation, but also to treat cardiovascular conditions in some patients. Be careful about checking warnings on each product and observing daily recommended limits, especially for acetaminophen as it may cause liver damage when used at high doses or by someone with abnormal liver function. Also, be aware some of these pain relievers, like acetaminophen, are added to multi-symptom cold formulas and prescription narcotic pain medications.

- Topical pain relievers (OTC)—creams and ointments with active ingredients such as camphor, menthol or other oils (like eucalyptus) and /or methyl salicylate which help to reduce localized pain. A few OTC creams contain capsaicin (like Zostrix) which, with repeated applications, is supposed to lower Substance P (a neurotransmitter for pain). The active ingredients in these products still get absorbed into the body and it is possible to use too much.

- Topical products, by prescription—compounding pharmacies can prepare creams with a variety of medications in them, like anti-inflammatory or anesthetic agents. Lidoderm are transdermal patches which contain lidocaine and used on sites of localized pain.

- NSAIDS (nonsteroidal anti-inflammatories) by prescription—Mobic (Meloxicam), Naprosyn (naproxen) and Celebrex (Celecoxib). These may cause considerable gastrointestinal upset and bleeding.

- Muscle relaxants—Zanaflex (tizanidine), Skelaxin (metaxalone), Lioresal (baclofen), and Soma (carisprodol) are the most common ones prescribed. They are used to relieve muscle spasm pain and stiffness, but each works in a slightly different way.

- GABA (gamma aminobutyric acid) inhibitors—these are medications which change the firing of certain nerve cells in the brain and were initially prescribed to control seizures. Neurontin (gabapentin) was the first such medication used for CFS/CFIDS/ME and FM to help treat neuropathy (nerve pain) while Lyrica (pregabalin), a derivative of gabapentin and manufactured by the same company, was recently approved specifically for FM pain. Lyrica seems to work well for some patients, while others experience too many troublesome side effects, including weight gain. The standard, recommended dosage has been found somewhat too high for many FM patients. Another drug used to control seizures in Europe, Lacosamide, is currently in US clinical trials as another treatment of pain in FM (estimated market date is around 2011). Its mechanism is considerably different from Neurontin and Lyrica by working on the hyperactivity of certain neurons, thus being able to raise the pain threshold, and possibly, without weight gain or sedation.

- Antidepressants—some of the same antidepressants prescribed to promote sleep have been found to reduce pain in some patients. One of the newer antidepressants, Cymbalta (duloxetine), was recently approved for the treatment of pain in FM and it works by increasing activity of serotonin and norepinephrine, which are thought to affect amount of pain one can feel.

- Migraines—there are range of medications used to treat migraine headaches. One of the older formulas that might be prescribed is Midrin (isometheptene mucate, dichloroacetophenone, and acetaminophen) which consists of three ingredients—one works on blood vessels, another provides a mild sedative, and the third is a common pain reliever. A newer family of migraine medications is the "triptans" family which includes Imitrex (sumatriptan)—it comes in oral form, nasal spray and as subcutaneous injections. Other related medications are Zomig (zolmitriptan) or Relpax (eletriptan). Extra caution needs to be taken in anyone who has co-existing cardiac problems. It is essential to also understand triptans should not be combined with SSRIs (or other medications that alter serotonin) which according to recent FDA alert can lead to Serotonin Syndrome. Another treatment approach is to try and prevent migraines with the use of beta-blockers (like Inderal) or calcium-channel blockers—verapamil, in particular (which has been studied as an effective prophylaxis of migraines). Other medications used to prevent migraines are some of the anti-seizure medications such as Topamax (topiramate).

- Non-narcotic pain relievers—Ultram (tramadol) or Ultracet (tramadol with acetaminophen). This medication is considered a cousin of the narcotic family and binds to certain opioid pain receptors and affects the re-uptake of norepinephrine and serotonin. Seizures have been reported in some people using Ultram.

- Opioid Analgesics—used to relieve moderate to moderately severe pain. Examples of pain medications in this group are Vicodin (acetaminophen and hydrocodone), Tylenol #3 (acetaminophen with codeine), Darvocet-N (propoxyphene), Percocet or Percodan (short-lasting oxycodone with acetaminophen or aspirin), oxycontin (a longer lasting controlled time-released agent) and/or Duragesic (fentanyl transdermal system). Several important warnings need to be made about fentanyl patches and their safety, especially given the incidence of accidental overdose and even death from these. The active ingredient is a powerful, rapid-acting opioid which is absorbed through the skin via a sustained release system. *Patches must be used exactly as prescribed, including placement which can affect drug absorption, and extra care should be taken not to damage nor cut them in any way because this could cause the opioid to leak and alter the dose received. Furthermore, numerous lots of fentanyl patches have been voluntarily recalled by different manufacturers due to defects which could cause an incorrect amount of medication to be released and absorbed.* All of these aforementioned medications are "controlled substances". Some are classified as Schedule II medications which means patients will need a new prescription for each month that they will be using one of these medications. Methadone, also in this category of medicines, has been gaining more recognition as an option for pain relief and is prescribed in very small

amounts by some leading FM specialists. Many of these medications could provide inexpensive, effective pain relief for a number of patients, but often they are not even able to try them. Many inaccuracies and myths surround this family of medications, like fears of patient addiction. The limiting of quantities, if or when they are prescribed, creates inadequate pain relief (as the effects of some last for only about four hours). Asking for better/ longer pain control is often viewed as drug-seeking behavior by the patient. A number of international CFS/CFIDS/ME and FM specialists recommend longer-acting, as opposed to shorter-acting, opioids in order to level off the up and down recurrence of pain.

- Dry needling and/or injections of trigger points—treatment primarily used in FM where patients' trigger points (points of knotted muscles from which pain often radiates) are isolated and either thin needles are inserted into these points/knots or they are injected with anesthetic agents. The goal is to reduce painful input to the central nervous system.

Fatigue and Cognitive Function

Disrupted sleep or poor quality of sleep and pain in themselves contribute to fatigue and impaired cognitive function. The ability to study sleep patterns, but also other brain activity patterns, has helped researchers see other deficits in these illnesses. Many clinicians working with CFS/CFIDS/ME and FM patients will prescribe medications which can increase alertness and concentration. On the other hand, some doctors don't support their use at all because they say increased firing of certain neurons, over time, may actually damage brain cells. Therefore, patients and their physicians need to take into account the effect of their fatigue and difficulty with concentration on their daily functioning, ability to work and overall quality of life versus the risks of these types of medications. They should also consider alternative options as there are a variety of supplements used to help promote mitochondrial energy production—these are [covered in our Supplements](#) section.

Though antidepressants are usually prescribed to help with sleep and pain, some can also provide an energizing/activating effect and improve mental clarity. This is accomplished according to how certain neurotransmitters are inhibited or increased, especially by a group of medications called, selective serotonin reuptake inhibitors (SSRI's) which primarily increase serotonin to the nerves.

Some examples of commonly prescribed SSRIs include Prozac (fluoxetine), Paxil (paroxetine), Lexapro (escitalopram) and Zoloft (sertraline). Weight gain, sexual dysfunction, anxiety and/or sleep disturbance are some of the more frequently reported side effects of these medications. Patients should be closely monitored for worsening symptoms of depression or

mood and/ or suicidal thoughts during first weeks of treatment.

One of the older medications used for its activating properties is Wellbutrin (bupropion)—it is defined as a norepinephrine and dopamine reuptake inhibitor and is chemically different from tricyclic antidepressants and SSRIs. A higher incidence of seizures has been reported in some patients using Wellbutrin than with other antidepressants.

Another medication in its own class is Provigil (modafinil) originally intended to treat daytime sleepiness found in narcolepsy. It is used to help relieve MS-related fatigue and more recently, to improve mental clarity in CFS/CFIDS/ME and FM. Its mechanism differs from most other stimulants as it primarily targets the part of the brain which keeps people awake. It may disturb sleep in some patients, even though this medication is taken during the early part of the day. The FDA issued a warning in 2007 that Provigil has been linked to serious skin rashes and psychiatric symptoms (i.e. anxiety, mania, or hallucinations) and urged caution if used for patients with a history of psychosis, depression, or mania.

Other stimulating medications are borrowed from Attention Deficit Disorder (ADD), such as Ritalin (methylphenidate) or Cylert (pemoline). Straterra (atomoxetine) is also in this category but is found not to be as stimulating as the older formulas. While they might help some people with concentration, they can also negatively affect mood and raise blood pressure. Sometimes amphetamines (like Adderall and Dexedrine) are prescribed to patients with CFS/CFIDS/ME and FM to improve concentration, even though initially these type of medications were used to suppress appetite, treat ADD and drowsiness in narcolepsy.

Two potential, underlying sources of fatigue may be an underactive thyroid and/or underactive adrenal glands. The thyroid gland in a number of individuals with CFS/CFIDS/ME and FM may either fail to produce sufficient amounts of thyroid hormones or their bodies make poor use of the hormones that are being produced. This, in turn, can cause fatigue, sluggishness, slowed metabolism and increased risk of iron and B12 deficiency. Some doctors will try to improve thyroid function by prescribing Synthroid or Armour thyroid, but it is important to realize there are various treatment approaches and interpretations of thyroid tests. About two-thirds of CFS/CFIDS/ME and FM patients are thought to have low adrenal function which can also cause fatigue, poor response to stress and predispose individuals to recurring infections. Some doctors will prescribe low-dose Cortef (hydrocortisone) to help support adrenal function, but others will regard this treatment as being controversial.

Doctors practicing holistic or integrative medicine may be more familiar and receptive to the newer treatment approaches as well as offer additional ways to help improve fatigue and energy production. Some commonly used alternative products are reviewed in our Supplements section.

Mood Disturbances/Depression

SSRIs (as described under Fatigue and Cognitive Function above) are also prescribed to help stabilize mood and/or reduce depression. The newer formulas will target other neurotransmitters along with serotonin, like norepinephrine. These are categorized as selective serotonin and norepinephrine reuptake inhibitors (SNRIs), Norepinephrine Serotonin Reuptake Inhibitors (NSRIs) and those primarily adjusting norepinephrine release are referred to as norepinephrine reuptake inhibitors (NRIs). These neurotransmitters have been found to affect pain, sleep, fatigue, cognitive as well as mood disturbance; therefore, adjusting these may provide improvement of these symptoms.

One of the newest SNRIs on the market is Cymbalta (duloxetine). Cymbalta's initial use was to treat major depression and anxiety. It has other properties which help to relieve nerve pain as well as improve one's mood, sleep, energy level, and decrease nervousness and as a result, the FDA approved its use for FM. Effexor (venlafaxine) was one of the first SNRIs which came out in 1993. This type of medication (as well as some benzodiazepines and sleeping pills) can be very sensitive to sudden interruption of use and may produce "brain sparks /shivers" in some patients (described as electric shock-like sensations in their brain but also extending to parts of the body, sometimes along with feeling of disorientation, vertigo and/or lightheadedness). Therefore, when any of these types of medications need to be discontinued, they should be tapered off gradually.

Milnacipran is the first NSRI to come on the market and it is different from Cymbalta, an SNRI, and older SSRIs, since it affects norepinephrine and serotonin in a more equal/ balanced way. During clinical trials, it was found to cause fewer undesirable side effects (such as sexual dysfunction). In January 2009, the FDA approved milnacipran for the management of FM, which will be sold under the brand name of Savella. It is expected to be available by prescription around March 2009. Reboxetine is another drug being studied in patients with FM. It is an NRI and currently used outside the US as treatment of depression.

Cardiovascular and Blood Pressure Irregularities

Autonomic nervous system (ANS) dysfunction can present as neurally-mediated hypotension (NMH) or orthostatic intolerance (OI), but there are several other related conditions that fall into this category. ANS-driven disorders are moderately common in people with CFS/CFIDS/ME and FM, including children and youth with CFS/CFIDS/ME, but are not limited to these illnesses. Basically, one's blood pressure will have an abnormal response to change of position (while standing) and the cardiovascular system will have to work much harder to maintain blood pressure and blood flow to the brain. Florinef (fludrocortisone) was one of the first treatments used to treat NMH by helping the body retain salt. Over time, it was found to lose its effectiveness because of potassium depletion and because it was not felt to be a very beneficial treatment. Other treatments might include medications to increase blood volume, work on vasoconstriction, or stimulate release of certain neurotransmitters.

Mitral valve prolapse (MVP), low cardiac output, and a distinct cardiac disorder called "diastolic cardiomyopathy" has been found in CFS/CFIDS/ME by one of the leading doctors, Dr. Paul Cheney, who has followed patients with this illness over the past two decades. "Diastolic cardiomyopathy" refers to the heart muscle's failure to relax and to not allow proper filling. It was noticed in most patients (though not all) with CFS/CFIDS/ME. This problem is undergoing more research and there no specific treatment recommendations at this time.

Studies by Dr. Lerner at the University of Michigan documented intermittent tachycardia in a very high percentage of 51 CFS/CFIDS/ME patients (1988 CDC definition for CFS). The tachycardia was accompanied by T-wave abnormalities as measured by 24-hour Holter monitoring. The studies found that 12 lead standard ECGs and 2-D echocardiograms do not generally show these cardiac abnormalities in CFS/CFIDS/ME. It is common for such abnormalities to be misdiagnosed as anxiety attacks, and thus of psychiatric origin. Instead, in Dr. Lerner's patients they seemed to be the result of viral infection.

Digestive Disturbances

Many people with CFS/CFIDS/ME and FM find they have food sensitivities and various digestive problems. Some patients develop acid reflux disorder or might experience bowel irritability, abdominal cramping, and/or changes in bowel movements.

Digestive enzymes can help to break down food which makes it easier to digest and absorb nutrients. These enzymes can also help to reduce bloating, gassiness, and heartburn. Sometimes heartburn or acid indigestion (especially if frequent) may be symptoms of a larger problem called Gastroesophageal Reflux Disorder (GERD), a digestive disorder in

which partially digested food and stomach acid and enzymes will back up into the esophagus. Sometimes, these secretions can travel all the way into the throat, which is then referred to as laryngopharyngeal reflux. The problem is usually caused by the lower esophageal sphincter muscle failing to close properly after food has passed into the stomach. Certain medications, like NSAIDS, some asthma, blood pressure, tranquilizer and other pain medications cause this muscle to over-relax while some medications can irritate the GI lining. Food allergies, especially dairy, certain deficiencies, but also chronic immune disorders can also contribute to development of GERD. The standard treatment is to use medications which will either reduce stomach acid or suppress it from being made (from Roloids to Tagamet or Pepcid (histamine H2-blockers) to proton pump inhibitors, like Prilosec or Nexium).

Though reducing or suppressing stomach acid may provide relief, it is important to realize the stomach needs a certain amount of stomach acid with which to sterilize food before it goes into the intestinal tract and to keep other bacteria in check, including yeast overgrowth. Plant enzymes and multi-strain probiotics are just a few of the digestive aids one might want to consider and review with his/her doctor. There are non-invasive things one can also do, like following a general anti-reflux diet, not laying down for 3 or 4 hours after eating, not bending at the waist after eating, elevating head of the bed by 4 to 8 inches, and taking extra measures to maintain regular bowel elimination.

One of the most commonly used treatments of Irritable Bowel symptoms is probiotics (which are actually dietary supplements containing beneficial bacteria or yeasts which can help to offset the overproduction of other (bad) bacteria). There are numerous formulas on the market but one particular formula containing *B infantis* was studied in FM patients and found to be especially effective. It is called Align and can be ordered from two of the leading drugstores. Xifaxan (rifaximin) is an antibiotic which is sometimes prescribed to kill off small intestinal bacterial overgrowth (which can be checked for via a lactulose breath test) and to treat diarrhea. This particular medication has been used to treat travelers' diarrhea and is used in many countries. There were two other medications marketed for treatment of diarrhea and abdominal pain in women, but these have been withdrawn by the FDA (though one, Alosetron (Lotronex), is occasionally used in very severe and resistant cases and can only be prescribed by doctors registered with the company).

Infections—Bacterial, Viral and Fungal

Many people who are diagnosed with CFS/CFIDS/ME can link their onset to some type of infection and a significant number of these individuals will continue to have recurring infections, such as sinus, respiratory system, cardiac, musculoskeletal and/or bladder. Many of the bladder infections are bacterial in nature and may require repeated courses of antibiotics. Very often,

urine will be cultured to determine the specific strain and which medication is the most effective in treating it. *Mycoplasma* and *chlamydia* are two types of microorganisms found fairly often in CFS/CFIDS/ME which can cause persistent infections. Many of these infections require more aggressive/ extended treatment than one standard course of antibiotics, and some infections respond better to specific types of antibiotics. General recommendations are not to take magnesium products within 6 hours of an antibiotic (as they can interfere with absorption of the medicine) and not to use antibiotics beyond their expiration date. It may be helpful to be on Nystatin, an antifungal medication, while on antibiotic treatment.

Yeast infections or yeast overgrowth tend to develop more frequently in patients with CFS/CFIDS/ME and FM which may be partially due to frequent infections requiring treatment with antibiotics (which will kill off both good and bad bacteria). Other factors promoting yeast overgrowth can be a diet high in sugar (sugar feeds yeast) and poor sleep which negatively impacts immune function. Yeast infections are often treated with Nystatin and/or Diflucan and Sporanox. The latter two medications are quite expensive and may increase risk of inflammation of the liver. Yeast overgrowth can be brought under control by using acidophilus / probiotic therapy, by avoiding intake of sugar and yeast products, and/or by adhering to a strict anti-*Candida* diet. There are many books as well as cook books written specifically on this topic.

A number of viruses have been implicated in CFS/CFIDS/ME, particularly from the herpes and enterovirus families. Antiviral agents, like Acyclovir and Famvir, have been prescribed in the past to treat some strains of herpesvirus infections, but have been found to be ineffective against HHV-6 and HHV-7. Valtrex (valacyclovir) was studied in CFS/CFIDS/ME patients with reactivated Epstein-Barr virus (EBV) and improvement of physical function and cardiac function was shown. Amantadine is another type of antiviral, usually used to treat Type-A influenza virus (at the onset of the flu) and is sometimes used in CFS/CFIDS/ME for its stimulating properties. A very potent antiviral agent called Valcyte (ganciclovir) is currently being studied in CFS/CFIDS/ME patients to determine if or how it blocks HHV-6, EBV, and other herpesviruses. The majority of the study patients experienced significant improvement. However, it is important to note that Valcyte is considered to be potentially toxic and patients must be very closely monitored while taking this medication. Ampligen is an immunomodulatory type of drug, which has remained in an experimental state for CFS/CFIDS/ME in the U.S. since 1988. It acts on double-stranded RNA. The New Drug Application submitted by the drug manufacturer to the FDA in late 2007 was regarded as incomplete. If /when the FDA approves Ampligen, it may be the first specific treatment for CFS/CFIDS/ME in the U.S. It is already approved by the European Union.

More Resources

[Complementary & Mainstream Treatment Approaches](#)

[Report on 6th AACFS Conference, 2003](#)

[Report on 8th IACFS Conference, 2007](#)

[A conceptual breakthrough? Very exciting findings on possible causes, tests, treatments for CFIDS symptoms](#) by Dr. David Bell

[Chronic Pain Control](#) by Dr. David Bell

[Comprehensive Treatment of Fibromyalgia](#) by Dr. Robert Bennett

[Dr. Klimas speaks to Mass. CFIDS on cutting-edge developments](#)

[Exciting and hopeful news for CFIDS research and treatment - Dr. John Gow's research on altered gene expression](#)