

Doc to Doc: The “Skinny” on Exercise and CFS

Exercise can be a tricky topic in the care of patients with CFS. On the one hand, exercise can lessen pain, improve sleep and increase energy levels. Deconditioning due to lack of activity only serves to undermine an already challenged body. On the other hand, one of the classifying symptoms of CFS is postexertional malaise, with significant exacerbation of symptoms following heightened activity. At times, these increased symptom levels can last for days following exertion.

Not surprisingly, many people with CFS express extreme concern at the suggestion of exercise as a treatment for the illness, fearing their physician will simply push them to join a gym and “hit the treadmill.” Unfortunately, some medical professionals—not fully understanding the complexities—take that misguided approach. With such concern and apparent misunderstanding on both sides of the examination table, three CFS-experienced clinicians share some practical advice on approaching exercise appropriately and effectively.

What role does exercise play in your treatment for CFS?

Lucinda Bateman, MD, Fatigue Consultation Clinic, Salt Lake City, UT

Exercise plays a critical role in my practice because it is such a double-edged sword—beneficial but tricky—and must be constantly addressed. During almost every visit, I ask patients what they are doing to maintain their physical strength and conditioning. That gets us talking.

Nancy Klimas, MD, University of Miami School of Medicine, Miami, FL

Exercise is important, both in the day-to-day management of symptoms and in the overall ability to improve over time.

Susan Levine, MD, Internist and Immunologist, New York, NY

The role exercise plays in my treatment of CFS patients depends mainly on the following factors: (1) the severity of their fatigability based on a subjective assessment of how long they can function at a particular task, such as grocery shopping or walking, before pushing the limit of overexertion; (2) motivation and accessibility factors, such as availability of a gym, a pool, stationary equipment or even an exercise buddy; and (3) whether they have associated disorders that might mitigate the benefits of exercise (such as cardiac problems).

Do you define exercise differently when treating CFS and, if so, how?

Bateman: We often think of exercise only as aerobic activity (walking, running, swimming, hiking, etc). I try to redefine exercise into three components: stretching, strengthening and aerobic activity. That gives all CFS patients something they can work on.

Levine: Exercise is different for patients with CFS. I would rather even use the word “movement” or name the specific activity that I want them to perform (such as walking or swimming). Movement promotes endorphin release and blood circulation, improves balance and increases strength. But it should be done cautiously, and the duration of the activity should be



kept at a minimum level, with only small increments of activity added every six to eight weeks.

What concern or resistance have you experienced from CFS patients when it comes to exercise? How do you address these concerns?

Bateman: Resistance comes from negative experiences with exercise itself and with physicians who don't seem to understand what the person is going through. My patients and I spend time every visit talking about their pain, fatigue, sleep, mood, function and payback symptoms—addressing exercise in the context of that communication.

I think everyone understands that their bodies become weaker without exercise, so it's easy for them to imagine how that might compound their CFS.

I encourage patients to “start low and go slow,” reminding them that they have all the time in the world to become stronger but can “crash” very quickly. I counsel them to do the amount of stretching, strengthening and light activity that will not cause any rebound symptoms the following day. We also discuss ways to do exercise lying down, seated or in water to avoid orthostatic intolerance.

Klimas: Most CFS patients will have concerns, and some are quite fearful of an exercise program. This is because all CFS patients will relapse with overexertion, and most are in the habit of pushing themselves over that invisible line of “too much.” But I believe patients who understand the reason they are so exercise intolerant are able to stick to a program that doesn't go over that invisible line.

Levine: Exercise is often a dirty word to the CFS patient. But if I phrase it in a way that sets limits on what I expect, they are usually comfortable. For instance, I define regular exercise for CFS patients, initially, as three to five minutes daily of mild aerobic activity, such as walking on a flat treadmill or walking around the block.

There are also ways to make exercise less threatening for the patient. Taking a small pet

on a walk or going out with a spouse for a short stroll can be beneficial and enjoyable.

The key is a *regular* program, no matter how short a duration, at about the same time every day.

What do you see as the greatest exercise-related risk for people with CFS?

Bateman: The greatest risk is a patient getting discouraged and falling away from all forms of exercise.

I also think some patients can develop more chronic pain or other symptoms from forcing exercise when they shouldn't.

I encourage patients to listen to their bodies, avoid pushing too hard when it might cause the most problems but come back to what they can tolerate when feeling better.

Klimas: I have come to recognize three basic risks. First, patients who push too hard every day never have a good day and are not able to improve because they constantly cross the line of overexertion. By backing off a bit and working up gradually, they will find that their overall exercise tolerance improves.

Second, patients who have been burned by bad exercise experiences can become afraid to try and, therefore, never gain the benefit of an effective program. They don't even know where their line of tolerance might be.

Third (and most common), patients who are clearly benefiting from a program, then relapse (no matter what the cause) are sometimes dramatically discouraged. When one of those fluke relapses hits them, they are emotionally crushed and struggle to find the motivation to start exercising again. The good news is that they don't lose all of the ground they so painstakingly won. But they are temporarily set back in their training program. Encouragement is key.

Levine: I think the greatest risk is a patient performing too much exercise on a day when he or she may feel better. Patients have to be told not to exceed their limits and to keep short diaries of their progress.

In addition, if going to a gym involves driving, changing clothes and other exertion, it may actually negate the positive benefits of the exercise itself. I generally encourage patients to find an exercise routine close to home.

EXERCISE ELEMENTALS

Nancy Klimas, MD, an experienced clinician and CFS researcher, treats people with CFS on a regular basis. When it comes to exercise, she offers the following basics.

Aerobic and anaerobic exercise are two different animals. Aerobic exercise is the running, swimming, keep moving until you are huffing and puffing form of exercise. It tones your cardiovascular system. But it will, in excess, push CFS patients into relapse.

Dr. Charles Lapp once performed a study using a treadmill and asking CFS patients to go until they had to stop. They all experienced postexertional relapse. He then brought them back in and asked that they do five minutes on the treadmill, lie down for five minutes, go another five on the treadmill, and so on. In this way the CFS patients were able to tolerate a cumulative treadmill time that far exceeded the “collapse” treadmill time. I have found that patients who perform five minutes of standing exercise can then switch to five minutes of flat mat work with a similar result. I often advise physical therapists and personal trainers to adapt an exercise program to allow maximum mat time.

Anaerobic exercise is the traditional strength training or weight/resistance exercise. But CFS patients don't need to try to bench press 220 pounds. Simple resistance training with elastic bands and very light weights will suffice. Exercise that is directed at increasing muscle mass will result in increased metabolic rate and the perception of increased energy.

I advise patients to learn an exercise program from an expert, and I write physical therapy referrals that are quite specific. I like patients to have a program they can do at home after some supervised time in a rehab center.

Lastly, stretching and flexibility exercise is a mainstay, particularly for those who also have fibromyalgia. Stretching compels muscles in spasm to relax and forces the muscle fibers apart. This form of exercise also results in a more balanced posture, helping prevent additional spasms by balancing the work of standing or sitting upright.

What do you see as the greatest benefit of exercise for people with CFS?

Bateman: Stretching, strengthening and light aerobic activity can help with flexibility, mobility, stamina and self-esteem. It can also help with pain and sleep.

Klimas: Exercise can put patients at a much higher level of functioning, and since it's in their control, it helps them realize that they have some influence over their illness.

Levine: Exercise is known to raise endorphin levels and thus helps with pain, mood and sleep problems. It may also maintain or build self-esteem. But the greatest benefit is to prevent further deconditioning.

Now that I am following long-term CFS and FM patients, I see how deconditioned they can get. Due to the chronic inflammatory nature of these illnesses, I am more concerned about the potential added risk of being sedentary. Does it add to their future risk of heart or other types of cardiovascular disease, stroke or diabetes? I don't know, but it certainly should not be ignored.

What parting advice can you give other medical professionals about prescribing exercise for patients with CFS?

Bateman: Listen to the patient. Experiment. Readjust as needed. Be creative about better-tolerated forms of exercise for that particular patient. Individualize the advice.

Klimas: (See sidebar.)

Levine: I would prescribe exercise if the patient has a sedentary job, is home on disability or experiences sleep and pain problems. Once again, I think the emphasis should be on short, regular, aerobic activity interspersed with yoga, stretching or light weights. In fact, if the latter activities are being done, the patient doesn't need to perform cardio exercise on those days but should have at least four weekly sessions of a minimum of three to five minutes of cardio as a goal. ■■