Excluded: Procedure not routinely funded

Policy Statement 36: Multiple Chemical Sensitivity (MCS) and Clinical Ecology/Environmental Medicine

Date of Issue: June 2001 (Berkshire Priorities Committee)
Ratified and adopted: April 2013

The Berkshire Priorities Committee reviewed the evidence of effectiveness for the treatment of multiple sensitivities or unexplained illness and recommends that patients should be treated by local NHS services which may include medical, psychological and therapeutic assessment and treatment. This is due to the limited evidence of clinical effectiveness of clinical ecology treatments and the uncertainties regarding the diagnosis and management of MCS. This is in line with other policies where non-NHS complementary therapy is also considered a Procedure Not Routinely Funded*.

MCS is also known as environmental illness, total allergy syndrome and idiopathic environmental intolerance (IEI). These terms do not refer to a clinically defined disease and the relationship between exposures and symptoms is unproven. The central focus of the diagnosis is the fact that patients self report symptoms in relation to exposures but there are no physical examination abnormalities. Diagnosis is typically made on the basis of patient history with no defining criteria, diagnostic symptoms or diagnostic objective physical signs. Provocation-neuralization testing, immunologic tests, psychological/psychiatric interviews and use of an ‘environmental control unit’ have not been validated as diagnostic tests either as single tests or in combination3,4,5,19,20. The IEI/MCS patient experiences wide ranging symptoms6 but evidence of pathology or physiologic function is lacking. A causal connection between environmental chemicals, foods and drugs and the patients symptoms continues to be speculative and cannot be based on the results of published scientific studies.

‘Clinical Ecology’ relies on the concept that multiple symptoms are caused by hypersensitivity to minute amounts of common foods and chemicals. Clinical ecologists hypothesize that repeated small exposures (or a single high exposure) to environmental agents can sensitize people and cause their immune system to malfunction. Once ‘sensitized,’ afflicted individuals become intolerant to a wide range of, and possibly all, synthetic chemicals5,6.

Many experts have concluded that the basis of MCS is psychological rather than physical2,7,14. Many MCS patients suffer from an emotional problem termed "somatisation disorder." This is characterized by persistent symptoms that no known medical condition can fully explain but that may require medical treatment. Controversies about specific theories of MCS, diagnostic approaches or treatment modalities should not preclude the compassionate care of patients presenting with complaints consistent with MCS.
Treatment usually emphasizes avoidance of suspect substances with lifestyle changes e.g. diet modification and to avoid synthetic items. More extreme restrictions include wearing a charcoal-filter mask, using a portable oxygen device, staying home for months, relocating, quitting a job, and avoiding physical contact with members of one’s family. Clinical ecologists also advise many patients to take vitamin, mineral, and other supplements.

Enzyme Potentiated Desensitisation (EPD) allegedly boosts the immune response against minute doses of allergens. So far, there has been a few small studies carried out mainly in Italy showing some marginal benefit for hay fever and other seasonal allergies, but these observations need to be confirmed by large-scale trials before they can be generally accepted as being efficacious. To date, no clinical studies have been conducted which compare EPD to standard allergy immunotherapy.

Besides the lack of a single case definition, several methodological problems limit the interpretation of published MCS research. These problems include over-reliance on surveys and self-reported symptoms, selection bias, lack of blinding, and inconsistent quality assurance of laboratory determinations. Many proposed outcome measures also require validation.

Several medical organisations have issued position papers pointing out the shortcomings of the MCS, the unreliability and misuse of certain diagnostic procedures, and the lack of scientific evidence of the alleged toxic effects from environmental chemicals in these patients. Therefore, it should be considered experimental. Likewise, the proposed treatments of rotation diet, avoidance, antifungal treatment for candidiasis, and provocation-neutralisation procedure, lack of sound scientific evidence to support their use. As for EPD, due to a lack of clinical evidence from well-designed, well-conducted clinical studies documenting the effectiveness of this form of allergy immunotherapy, it should be considered investigational.

REFERENCES:

22. Royal College of Physicians and Royal College of Pathologists. Good Allergy Practice: Standards of care for providers and purchasers of allergy services within the National Health Service. London, October 1994.

NOTES:
1. *Procedure not routinely funded formerly known as Low Priority/Procedure of Limited Clinical Value/Never Dos
2. Exceptional circumstances may be considered where there is evidence of significant health impairment and there is also evidence of the intervention improving health status.
3. This policy will be reviewed in the light of new evidence or guidance from NICE.
4. Further information on policy statements is available from http://www.fundingrequests.cscsu.nhs.uk/