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Sir,

I read with interest the papers on the chronic fatigue syndrome (August *Journal,* p.324, 339). This syndrome has become an important diagnosis in both general practice and psychiatry. With the awareness of such a diagnostic entity, more patients are being recognized and managed (although the aetiology still remains unknown).

Depression as an inherent feature of chronic fatigue syndrome remains a controversial issue and great care is needed in treating these patients as 'depressed'. Subjectively, many patients with the chronic fatigue syndrome describe their mood state as depressed, probably because of lack of any other socially approved metaphor. For a practitioner, however, it is important to make an objective assessment about the significance of this expression in terms of the range and reactivity of affect and the disproportion of depressive presentation in the context of the patient's life situation and experiences. If depression is significant, the diagnosis of chronic fatigue syndrome becomes secondary to that of depressive disorder as fatigue may be a feature of depression. However, if chronic fatigue syndrome remains the primary diagnosis, one must remember that antidepressant drugs are neither euphoriants nor stimulants and that there is no empirical evidence for the benefit of antidepressant treatment in this syndrome, although there is a recommendation for it to be tried as an alternate mode of treatment.

Although viral infection[1-3] and minor immunological aberrations[3-7] have been implicated in the aetiology of chronic fatigue syndrome, one is reminded of the concept of neuraesthenia first described by Beard in 1869.[8] The core features of this disorder were a reduced capacity for the output of energy and mental and physical effort, a lack of initiative and an unwillingness to undertake new activities. Slater and Roth suggested that patients with chronic fatigue syndrome are 'rarely accessible to psychotherapy. They frequent the surgeries of general practitioners and are as a rule satisfied with the prescription of tonic medicine or some other placebo. The patients are frequently helped by monoamine oxidase inhibiting drugs, which may be given for some weeks at a time with intermissions. Some patients feel normal on a dose of dexamphetamine'.[9]

Other treatments tried for chronic fatigue syndrome are high dose acyclovir,[3] intramuscular liver extract-folic acid-cyanacobalamin,[10] intramuscular immunoglobulin,[11] high dose intravenous immunoglobulin G monthly,[7] a mixture of evening primrose oil and fish oil containing gamma-linoleic acid and eicosapentaenoic acid[12] and intramuscular magnesium sulphate weekly.[13] However, none of the treatments have shown any promising results.

Since there is no definite recommendation about treatment for the chronic fatigue syndrome the patient should probably be given the treatment that is the personal preference of the treating physician. This may include cognitive behaviour therapy, increasing physical activity, analgesics, non-steroidal anti-inflammatory drugs or antidepressant drugs.

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Sir,

Ho-Yen and McNamara give an interesting account of general practitioners' experience of the chronic fatigue syndrome (August *Journal,* p.324). However, many of the conclusions which they draw are not supported by their study.

The problem lies in the method by which cases were identified. It seems unlikely that the doctors who responded to the questionnaire would have screened every patient on their practice lists for the condition. Even to screen only those patients who attended the surgery would have been a massive undertaking. There is no evidence that the practices involved kept a case register for this illness. I presume therefore that the cases reported were identified from memory by the doctors who responded to the survey.

Thus, for patients who meet the criteria for this illness to be identified as a 'case' they must: decide that they are ill, decide to visit the doctor, be correctly identified as a case by the general practitioner and leave such an impression on the doctor's mind as to be easily recalled later. It is very unlikely that, having passed through such a selection procedure, the cases identified would represent either the true number or display the typical characteristics of patients with this condition in the general population.

Indeed, the selection process outlined above could well explain some of the results obtained. Patients with more severe illness and those not attending work are more likely to visit their doctor, accounting for the high proportion of patients with these characteristics. Similarly, those who take up 'a lot' or 'excessive' amounts of a general practitioner's time are far more likely to be remembered and included in the study, explaining why nearly half of the women and over 40% of the men fell into these categories. The large variation in 'prevalence' rates between districts is far more likely to be due to differences in rates of detection than to differences in the underlying prevalence in the community or even in practice attenders.

This study is a valuable subjective account of general practitioners' experience of and attitudes to the chronic fatigue syndrome. It is not a study of the prevalence of this condition or of the characteristics of its sufferers in the general population or in the population of general practice attenders.

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