Postgrad Med J (1993) **69**, 164 - 166

Letters to the Editor

The chronic fatigue syndrome

Sir,

Although many doctors equate chronic fatigue syndrome (Oxford definition) with what we call myalgic encephalomyelitis (ME),[1] there are some noteworthy differences.

Firstly, in Britain, chronic fatigue syndrome is an umbrella term covering a number of different conditions including neurasthenia, effort syndrome and fibromyalgia. ME is a more specific entity (see the *International Classification of Diseases* **10**, 1992) and unlike the above, has been closely linked to a persistent infection and immune system activation.

Secondly, while profound fatigue is undeniably the most common symptom of ME, it is rather different from the type of tiredness which people normally experience after exertion.[2] For example, it is often accompanied by feelings of illness which are so unlike anything which people have had before that patients frequently say they cannot describe it. Some have referred to the latter as a severe 'flu-like malaise, others have likened it to being poisoned. Regrettably, having subsumed ME under a general heading of chronic fatigue syndrome, this important and disabling aspect of ME will almost certainly be overlooked.

As far as psychological symptoms are concerned, the most common are emotional lability and depression. In the majority of ME patients, these tend to fluctuate and generally improve with rest, understanding and social support.[2] The 'lack of interest in all aspects of living' referred to in the paper by James *et al.* is, in our opinion, more typical of clinical depression than ME and this is also the case for anhedonia, apathy and 'low-spiritness'.

In fact, since it has been shown (Goudsmit, personal communication) that the rates for clinical depression are markedly higher in chronic fatigue syndrome (Oxford definition) than in ME or chronic fatigue syndrome (defined using the more rigorous US/Australian criteria),[3,4] the presence of persistent anhedonia and apathy may be yet another way of distinguishing between the two.

There are a number of other differences between ME and chronic fatigue syndrome, including the patients' attributions and their response to exercise. Clinicians who would like to know more about the true nature of ME can contact either the ME Association or the ME Action Campaign for details.

A. Macintyre
M.C. Hume
International Federation of ME Associations,
23 Melbourne Road,
Teddington,
Middlesex TW11 9QX, UK.

References

1. James, D.G., Brook, M.G. & Bannister, B. The chronic fatigue syndrome. *Postgrad Med J* 1992, **68:** 611-614.
2. Macintyre, A. *ME Post-viral Fatigue Syndrome. How To Live With It*, 2nd ed. Thorsons, London, 1992.
3. Sharpe, M., Hawton, K., Seagrott, V. & Pasvol, G. Follow-up of patients presenting with fatigue to an infectious diseases clinic. *Br Med J* 1992, **305:** 147-152.
4. Peterson, P.K., Schenck, C.H. & Sherman, R. Chronic fatigue syndrome in Minnesota. *Minnesota Med* 1991, **74:** 21-26.

Diagnosis and management of ventricular tachycardia

Sir,

In his excellent review, Dr Dancy drew attention to the fact that ignorance of the predictive power and prevalance of criteria for ventricular tachycardia (VT) could lead to underdiagnosis of this condition in patients with broad QRS tachycardia.[1] In the presence of rapid atrial fibrillation underdiagnosis can also occur, this time as a result of the mistaken belief that, in VT, 'the ventricular rhythm is usually slightly irregular'.[2] The qualification which is sometimes omitted is that monomorphic VT, that is, the variety most likely to be confused with supraventricular tachycardia, is typically regular,[3,4] the occasional variation in R-R interval amounting to no more than 40 milliseconds,[4] characteristically as a result of interposition of fusion beats[5] or capture beats. Disregard for this caveat can lead to misdiagnosis of fast atrial fibrillation as VT in patients with pre-existing bundle branch block, especially because, at very rapid ventricular rates, irregularity of rhythm is less obvious than at slower ventricular rates.

In Wolff-Parkinson-White syndrome with fast atrial fibrillation, diagnostic confusion is compounded by the occurrence of ventricular complexes simulating fusion beats.[5,6] An equally confusing situation could occur in non-Wolff-Parkinson-White cases with atrial fibrillation and bundle branch block as a result of vagaries of acceleration-dependent aberration,[7] in a manner analogous to the occurrence of fusion beats in supraventricular tachydcardia with bundle branch block, due to intermittent partial bundle branch block interrupting complete bundle branch block.[8]

O.M.P. Jolobe
Department of Geriatric Medicine,
Tameside General Hospital,
Fountain Street,
Ashton-under-Lyne,
Lancs OL6 9RW.

References

1. Dancy, M. Diagnosis and management of ventricular tachycardia. *Postgrad Med J* 1992, **68:** 406-414.
2. Goldman, M.J. Ventricular tachycardia. In: *Principles of Clinical Electrocardiography*. Lange Medical Publications, Los Altos, CA, 1976, pp. 252-258.
3. Wellens, H.J.J., Bar, F.S.H.M. & Lie, K.I. The value of the electrocardiogram in the differential diagnosis of a tachycardia with a widened QRS complex. *Am J Med* 1978, **64:** 27-33.
4. Rowlands, D. Pre-excitation and re-entrant tachycardia. In: *Understanding the Electrocardiogram*. Gask and Hawley, Manchester, Section 3, 1987, pp. 454-470.
5. Linker, N.J. & Camm, A.J. Irregular ventricular tachycardia. *Hosp Update* 1989, November, 857-862.
6. Garratt, C., Ward, D., Antoniou, A. & Camm, A.J. Misuse of verapamil in the pre-excited atrial fibrillation. *Lancet* 1989, **1:** 367-369.
7. Fisch, C. & Knoebel, S.B. Vagaries of acceleration-dependent aberration. *Br Heart J* 1992, **67:** 16-24.
8. Griffith, M.J., de Belder, M.A., Linker, N.J. *et al.* Multivariate analysis to simplify differential diagnosis of broad complex tachycardia. *Br Heart J* 1991, **66:** 166-174.