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Chronic fatigue syndrome

As neurologists in a country where the chronic fatigue syndrome (CFS) has almost no recognized official existence, we often feel bewildered by the papers on the subject we read in the Anglo-Saxon literature. We wonder whether the clinical experience of some of their authors is so different from ours that they do not consider that their approach may result in a disservice to their patients. The JNNP has followed a sensitive line culminating in Wessely's excellent editorial.¹ We still, however, feel that his kid-glove handling of the subject reflects the controversy that surrounds it in the UK.

Avoiding the futile organic versus functional debate, in our neurology department we refer to many of the problems we see in our practice as the "chronic vigilance syndromes": specific patterns of enhanced attention centred on particular bodily structures and functions. Naturally, the commonest in a neurologist's outpatient clinic are the "cephalic vigilance syndromes" in their two main forms: the painful, with its several varieties of chronic headaches, and the operational one with its subjective unsteadiness, concentration problems and various odd turns. "Thoracic vigilance" patients are often referred to cardiologists or pneumologists but a fair number also come to us, especially if they have hyperventilation symptoms such as dizziness and paraesthesiae. Among the different types of patients with fatigue we are also familiar with the occasional "neuro-muscular vigilance" patient whose symptoms parallel your CFS cases. We have the non-controlled impression that in our environment such patients often have a premonitory preoccupation with their locomotor system.

We believe that an important element in all these syndromes consists of the patients' misconceptions about the causes, mechanisms and prognosis of their symptoms derived from popular health concepts and also not infrequently from counterproductive health education campaigns and doctors' remarks. In fact, we find it remarkable that the influence of the public and medical interest in CFS on its proliferation does not figure prominently in any discussion. That is why our approach to these syndromes consists mainly of a kind of "cognitive therapy" which tries to bring to the fore the patient's ideas on the problem and to demolish misconceptions, together with a sparing use of drugs. Our experience tells us that whereas some of these syndromes can be dealt with reasonably well, others are much more resistant. Such is the case for example with the "facial vigilance syndrome", better known as atypical facial pain, and the "neuromuscular vigilance syn-

drome". Fortunately the latter is not common in our environment.

But not for long. Our compatriots are starting to be taught about this "new" disease. The widely read Madrid newspaper *El Pais* ran a full page story on the CFS as "the disease of the nineties". A highly-reputed private teaching hospital has also given press releases on this "impending epidemic" and even a local newspaper has informed our neighbourhood about the shape of things to come. Some months ago a chat-show on Spanish television hosted the "first" Spanish patient with CFS.

So now we are bracing ourselves. Wessely quotes an article on "the role of culture in making a diagnosis".² There is also a role for culture in developing and expressing illness. Our colleagues are being educated in this new pattern of self-vigilance, and the successful incorporation of Spain into the Western democracies will be enriched by this new cultural acquisition. They will also be taught that this disease is chronic, long-lasting, makes inactivity advisable and has no treatment: a self-fulfilling recipe for chronicity. They will learn to mistrust doctors who suggest that their symptoms, real, disabling and worthy of treatment as they are recognised to be, may not be due to a testable specific organ disease: a mistrust that will deny them the first step towards improvement. And presumably we Spanish doctors will soon start publishing papers on CFS.

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- 1 Wessely S. Chronic fatigue syndrome. *J Neurol Neurosurg Psychiatry* 1991;54:669-71.
- 2 Abbey S, Garfinkel P. Neurasthenia and chronic fatigue syndrome: the role of culture in the making of a diagnosis. *Am J Psychiatry* (in press).

Wessely replies:

Dr Digon and colleagues believe that cultural factors play a vital role in the aetiology of CFS, a view I can only share. There is a considerable degree of iatrogenesis in the rise of these conditions, and if one is to understand their sudden rise, and occasional fall, it is essential to understand cultural attitudes towards health and illness, and in particular prejudice against conditions which, whether fairly or not, are frequently seen as psychological in origin.¹² We have previously concluded that such prejudices and unhelpful polarisation between "physical or psychological", which all too often means "real or unreal", may be more virulent than any virus.³

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BOOK REVIEWS

All titles reviewed here are available from the BMJ Bookshop, PO Box 295, London WC1H 9TE. Prices include postage in the United Kingdom and for members of the British Forces Overseas, but overseas customers should add £2 per item for postage and packing. Payment can be made by cheque in sterling drawn on a United Kingdom bank, or by credit card (Mastercard, Visa or American Express) stating card number, expiry date, and your full name.

Post-Viral Fatigue Syndrome. Edited by R JENKINS AND J MOWBRAY. (Pp 463; Price £60.00). Chichester, John Wiley & Sons Ltd, 1991. ISBN 0 471 928461.

What is regarded as increasing enlightenment, or perhaps an increased journalistic interest in medical matters, has led to much more "self-diagnosis" in the Neurology Clinics. One of the more popular diagnostic labels attached to the patient by himself or his informed friends, is myalgic encephalomyelitis or ME.

Many patients attending the clinic, convinced of the correctness of the diagnosis will bring evidence of confirmation from specialist practitioners and organised groups and will not be persuaded otherwise. They will not accept that there is an alternative explanation for their problems to "post-viral fatigue" or whatever. These patients pose a considerable problem. It is not surprising that an attempt has been made to rationalise this "syndrome", to give it an identity as a nosological entity, consider the pathogenesis, importance, and implications and to define the diagnostic criteria.

This book is edited by a principal medical officer at the department of health, a psychiatrist by training and a professor of immunopathology. They have invited contributors from diverse backgrounds to discuss their involvement in ME and to resolve the "particularly challenging problem for contemporary medicine... those puzzling clinical entities which are defined purely in terms of symptoms, which are accompanied by little in the way of consistent physical signs, which affect quite large numbers of patients for which no specific treatment appears effective".

Thirty-five contributors address the problem in a book of 275 pages. It is stated unequivocally on page 167... "it is however beyond any doubt that muscles are involved in this syndrome with both metabolic and ultrastructural abnormalities" and yet on page 237 the more orthodox neurological view is expressed... "our management of patients... is based on our belief that the condition forms part of the spectrum of a depressive illness, triggered by a viral infection". The psychologist, recognising that it has "attracted much controversy" concludes that it is not clear whether we are dealing with a single syndrome or with a heterogeneous group of disorders which share some common characteristics.

It is stated that because "you don't get a temperature with a nervous breakdown, the patient must be asked to buy a thermometer and not to leave the chemist's shop until he has been shown how to read it". The author then tells us that many of the patients with ME do not run fevers. The book simply brings together all the conflicting points of view and leaves the reader in considerable doubt as to whether there is here a nosological entity. We are advised as clinicians to exclude all the possible causes of fatigue and when with diligence this has been achieved then consider that there is a genuine disorder of muscle fatigue which constitutes ME.

I feel that most clinicians with experience of these patients would accept the orthodox view that the majority are depressed and will respond to advice and tricyclic drugs, and after the organic causes of fatigue have been excluded in the remainder, there is little left. This reviewer does not agree with Merry who writes that "the climate of medical opinion, although as slow to move as the bowels of the earth, seems to be shifting gradually towards regarding ME as an organic disease and less as a figment of the imagination," and feels, that acceptance of the disease will help, "a great deal in providing a broad basis for research". He encourages the active support of the ME association and instances the "magnificent work with the VP1 estimations", but endorses the use of acupuncture, only when undertaken by an experienced practitioner, "as poor results result otherwise".

An unconvinced and somewhat biased reviewer, but hopefully not a biased review.

JB FOSTER

Traumatic Transtentorial Herniation and its Management. By B T ANDREWS AND L H PITTS. (Pp 152; Price: \$40.00.) New York: Futura Publishing Co. 1991. ISBN 0 87993 383 6.

This monograph describes the management of severe head injuries presenting with the clinical signs of transtentorial herniation, that is unilateral or bilateral fixed dilated pupils with depressed consciousness and hemiparesis. The authors are senior neurosurgeons at the San Francisco General Hospital Medical Centre, University of California.

The book starts with the anatomy and clinical manifestations of transtentorial herniation, and then sets out the initial assessment, resuscitation, investigation and surgical and ITU treatment of these patients. Every neurosurgeon and trauma specialist will be interested in the management protocol which the UCSD has adopted for this very difficult clinical problem. The authors attempt to justify their main point in management, the use of bilateral burr holes prior to CT scanning, because they believe that in these patients who are rapidly deteriorating, the delay whilst a CT scan is performed is critical. The statistics with which they back up this belief are based on 153 cases, of which 68% die and 18% had a good or moderately disabled recovery. During the burr hole procedure intraoperative ultrasound is used to scan for haematomas within the brain substance. The authors accept that there is no statistical validation of their protocol, and also note that their views are controversial.

Although this book contains useful information, apart from the use of surgery before scanning and intra-operative ultrasound, it does not make any other new management points. It is questionable whether it justifies a whole monograph, although it is reasonably priced at \$40.00 U.S.

MICHAEL POWELL

Pain and Central Nervous System Disease: The Central Pain Syndromes. (The Bristol-Myers Squibb Symposium on Pain Research.) Edited by KENNETH L CASEY. (Pp 290; Price: \$115.00.) 1991. New York, Raven Press. ISBN 0 88167 776 0.

In 1969, Cassinari and Pagni wrote the only monograph on central pain until the present book appeared. This book, an excellent account of developments since that time, comprises chapters from 26 authors who contributed to a Symposium on Central Pain held in Michigan in July 1990. The book is particularly important since the field covers numerous related topics which are spread widely in the scientific literature, and it is difficult to summarise the "state of the art", a task achieved here admirably.

The book is divided into sections comprising clinical aspects of central pain states: assessment, measurement and behavioural issues; anatomy and physiology relevant to central pain states; chemohodology and pharmacology; and therapeutic aspects.

Certain problems recur throughout the book, for example, what precisely is central pain? This is no problem for post-stroke pain syndromes, but if, as is so amply discussed, widespread changes occur in the central nervous system following purely peripheral painful lesions, does separation of central and peripheral pain still make sense? Nevertheless, here is the place to find out about pain after strokes and spinal cord injury, about what happens in the spinal cord and thalamus in central pain, about denervation supersensitivity, neuronal plasticity, what the relevant pathways might be, what the most useful drugs and augmenting and ablative procedures are for helping these patients. And much more.

The contributions have been very well written and edited, the book is extremely up-to-date and immaculately produced.

GD SCHOTT

MRI of the Central Nervous System: A Pathology Atlas. Edited by K MORI. (Pp 241 Illustrated; Price: DM 220.00). Heidelberg, Springer-Verlag, 1991. ISBN 3 540 70069 2.

As the title implies, this book is predominantly an atlas of abnormal magnetic resonance images of the central nervous system. In many cases, comparable computed tomograms are included and some angiograms and plain films are also illustrated. Many of the pathologies are histologically confirmed, though no specimens are illustrated. In congenital abnormalities for example, the diagnosis is evident from the images alone; in others such as vascular diseases, confirmation is by other radiological studies.

The text is brief and at an elementary level. Short chapters deal with the basic principles of magnetic resonance and of normal and abnormal signal production; and, an anatomical atlas displaying normal sections of the brain and spine with labelled line drawings is included, though only the very major anatomical features are indicated.

Most of the common abnormalities indicated are included but the range of pathologies is by no means complete. In general the cases selected to illustrate a particular condition demonstrate the important and typical features on which the diagnosis depends. However, there is no labelling of illustrations or line drawings in this part of the book and many details visible on the illustrations do not receive any comment in the captions.

Most of the images were produced on an Hitachi 0.5 Tesla super-conducting system. With few exceptions, they are of good quality and are always adequate to demonstrate the pathology. There is a good bibliography but the latest references are from 1988. The book is at too elementary a level to be useful to neuroscientists. It is suitable for students and perhaps for general radiologists and physicians beginning to study the central nervous system with MRI but unfortunately, it is relatively expensive.

BRIAN KENDALL

Disturbances of Lower and Higher Visual Capacities Caused by Occipital Damage. History of Neuroscience Series/2. By W POPPELREUTER. (Pp 370; Price £20.00.) Oxford, Clarendon Press, 1990. ISBN 0 19 852190 1.

This book published by O.U.P. has been translated by Zihl with the assistance of Weiskrantz. The value of this exercise goes far beyond an opportunity to put Poppelreuter's ideas into an historical context because so much of this material is unfamiliar to us and remains illuminating in its own right. The preface to the translation gives a brief biography of Poppelreuter. The translator has achieved a deep understanding and we are well prepared for Poppelreuter's approach to his subject and the internal and external factors which shaped it, and those which later condemned it to unjustified neglect.

Poppelreuter did not consider his clinical material (cases of missile injuries to the brain sustained in World War One) to be suitable for a study of localisation of function and none is attempted. Thus we do not find the intensive methods of accurate localisation of lesions and the emphasis on the topographic aspects of the visual field defects which occupied Inouye and Holmes. Not only was he sceptical of the concept of a point to point representation of the visual field in the cortex but the location of the damage was irrelevant to Poppelreuter's ultimate objective: rehabilitation. This interest, however, generated a comprehensive account of the functional consequences of the occipital damage in these patients aided by a thorough grounding in Gestalt Psychology. Each aspect of visual function is heralded by an essay describing the basic psychological principles, these are charged with Poppelreuter's own ideas but are also excellent summaries of the state of