Having started with a 'negative' profit in my first years in the National Health Service, I had to buy a house and a share of the practice property, at an inflated value, etc. and I eventually had an overdraft of some £15,000 to £20,000 before I was able to start paying this off, mostly by inherited "monies". I think that this was the anchor to my practice and not laziness or disinclination to uproot.

D.HUTCHISON

REFERENCE

Butler, J. R. & Knight, Rose (1975). *Journal of the Royal College of General Practitioners*, **25**, 496–509.

MYALGIC ENCEPHALOMYELITIS

Sir,

I and some fellow doctor-sufferers of myalgic encephalomyelitis would like to form a group with the aims of furthering research into this unusual illness and providing help and support for fellow-sufferers.

Acheson (1959) wrote the classical description of this illness. We have no doubt that the disease is not hysterical, but an organic entity, but because of the protean nature of the clinical picture difficulty in diagnosis remains our chief problem. In other virus diseases like glandular fever or infective hepatitis two or more attacks can occur, but myalgic encephalomyelitis is unique in my experience in relapsing ten or more years after the original attack.

Permanent damage to the central nervous system may be sustained with slow deterioration and a feature of the 'relapses' which distinguishes them from multiple sclerosis is the severity of the pain unresponsive to the usual analgesics, and the malaise and weakness which apart from a low fever, show very little in the way of positive physical signs to account for them.

We would like to establish some criteria for diagnosis, such as a typical history in chronic relapsing cases and a preceding sore throat or attack of diarrhoea and vomiting in acute ones. An extreme pallor, enlarged glands, generalised muscle weakness with tenderness in some cases, increased jerks, giddiness and a history of conjunctivitis are other features.

Fluctuation of symptoms from day to day and at different times of the day is almost diagnostic, but may mistakenly be assumed to be hysterical. The association of neurological signs and symptoms such as difficulty in walking with evidence of gastrointestinal disturbance, e.g. nausea, anorexia and abdominal pain should make one suspect the diagnosis.

In my experience, symptoms are characteristically worse on lying down and pain is frequently so severe at night it wakes the patient in the early hours of the morning. Fatiguability is a constant feature and rest is essential in the early stages as aggravation of symptoms after exertion is responsible for the frequent relapses during convalescence.

At present there is no definitive diagnostic test, but a serum pyruvic acid or lactate or muscle biopsy have been suggested as possible lines of research.

The cause of the illness is unknown, but in a chapter on the central nervous system in the April 1975 issue of *The Practitioner* devoted to autoimmunity, disseminated encephalomyelitis was linked with multiple sclerosis, myasthenia gravis, and lupus erythematosis. It is interesting that it has features in common with all three and in my opinion could be either a slow virus infection of the CNS like multiple sclerosis, but producing more signs of encephalitis than myelitis, a multisystem auto-immune disease like lupus erythematosus, or a myopathy like myasthenia gravis.

It is our impression that the disease now largely goes unrecognised, unless it erupts in an outbreak at an institution. But sporadic cases do occur and we would like your help in identifying them. General practitioners see more cases than hospital consultants particularly in the less severe forms and can see the different ways members of the same family are affected. This therefore seems a piece of research which the R.C.G.P. is particularly well qualified to undertake.

CELIA WOOKEY

51 Lake View,
Edgware,
Middlesex.

REFERENCE

Acheson, E. D. (1959). *American Journal of Medicine*, 569.

HOURS ON CALL

Sir,

Surely Dr Dermot Lynch was joking in his letter in the May *Journal* when he said that after a 40-hour week 20 hours of standby, with two attendances created a tension state leading to fatigue.

This seems to me to be general practice at its leisurely best. A five-day week, each day of eight hours, work, and, after two emergency consultations taking perhaps half an hour each, 19 nail biting hours of on call!

I. D. KERR

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Tiverton,
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REFERENCE

Lynch, D. (1975). *Journal of the Royal College of General Practitioners*, **25**, 396.

THIRD INTERNATIONAL CONGRESS ON GROUP MEDICINE

Sir,

The third International Congress on Group Medicine is to be held in Paris next June. I am