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 auto-immunity, 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 multi-system 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,
Devon, EX1 6NJ.

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

attempting to collect facts about group practice in the United Kingdom on behalf of the Scientific Committee of the Congress. It appears that, in the United Kingdom, this form of practice is confined to general practitioners. In many other countries there are groups of specialists and also groups of specialists and general practitioners working together.

I would be most grateful if any doctor in Britain who practises in such a group or who has knowledge of one would send me the facts.

JOHN MARKS

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BOOK REVIEWS

The Smoking Problem and the Family Doctor (1975). Proceedings of a joint symposium sponsored by the Scottish Council of the Royal College of General Practitioners and the Scottish Committee for ASH: November 1943. 59 Pp. Edinburgh: Scottish Health Education Unit.

Most doctors in the College were not at this symposium; and most will welcome the simple way in which these proceedings have been prepared for the absentees. Many facts, a few opinions and much discussion on the burning topic in preventive medicine: Why stop? Who stops? Who can't stop? Stop or cut down? Is anything "safe"?

Some of the matters discussed in detail are: the long-term damage to fetal development; the identification of vulnerable children in vulnerable households with respiratory disease; the potential "coronary" victim; the role of nocotine, tar and CO; hypnotherapy in the surgery; the problems of the medical nicotine addict; and is health education failing?

An encouraging feature is the number of family doctors in Scotland who are studying the problem in their own practices. In part this too may be, as the report itself is, a tribute to the energies and skill of the late Dr Ian Stokoe who contributed so much to the success of the symposium held at the Royal College of Physicians, Edinburgh.

G. I. WATSON

Bedside Diagnosis (1974). Tenth edition. SEWARD, C. assisted by MATTINGLY, D. Pp. 548. London: Churchill Livingstone. Price: £4·00.

The tenth edition marks the twenty-fifth year since first publication. The entire text has been revised and some chapters have been wholly rewritten. A formidable gathering of experts has supervised and contributed. Considerable thought has been given to the theme of doctor-created illness and the side-effects of treatment. Advances in therapy and in the mode of action of drugs are looked at afresh. There is a new chapter on the causes of coma.

Those who know the book's format will be aware that it is intended to be complementary to the formal text book, linking such traditional publications with the patient's bedside. The basic structure is that of a systematic analysis of important symptoms and signs. Such a method is appealing because one's problems are often not so much of 'knowing', but are rather those of difficulty in recalling one's knowledge in an orderly fashion. Conversely, however, the design of the book produces problems of rigidity and of artificiality, for example, the subject of hypertension is covered in the section entitled *Head Pain*. Furthermore, the tone of the book is inevitably didactic and the prose style staccato.

There are several printing errors, but the typescript is clear. There are a few other faults of commission and omission. The expression "coronary infarction" is irksome and it is surprising to find constipation regarded as a cause of headache. I am also reluctant to accept aerophagy and irritable colon as causes of thoracic pain. The author's view on faecal occult blood tests are dangerously wrong. And why is there no section on lumbar pain?

The overall impression is however, of real achievement, and a wealth of medical wisdom is contained in this little volume. It gives the feeling of possessing the distillate of several lifetimes' experience.

Beautifully produced, *Bedside Diagnosis* is a pocket supermarket in facts for the candidate and the working clinician. It is regrettable that such a book didn't come from general practice. "Good gear goes in small bulk"—and for only £4.00.

DAVID G. ILLINGWORTH

A Guide to Counselling and Basic Psychotherapy (1975). RICHARD PARRY. Pp. 129. Edinburgh: Churchill Livingstone. Price £1·75.

As a description of the way in which one man finds he can help some people to resolve some of their difficulties with people, this book is appropriate reading for all general practitioners. As a way of acquiring the personal skill of psychotherapy (or counselling—the author uses the words synonymously) this book could only contribute to the background reading. Those who start a book at chapter one, are advised to read the author's preface carefully, otherwise the authority of the printed word causes personal assertions to look like cast-iron universal rules.