homoeopathic potency versus placebo[3] by Reilly, a College member, in a paper which emphatically contradicts their assertion that critiques of homoeopathy remain ignored and unanswered. Critiques, incidentally, which are to be found in the increasingly self-critical pages of contemporary homoeopathic journals, as well as in the reference (was the date, 1853, really correct?) that they quote.

The proper relationship between doctors' interest in complementary therapies (which might not be unrelated to patient advantage), their role in primary care, already discussed in this *Journal*,[4] and appropriate provision of training does need to be carefully assessed, but the comment that 'The interest ... is not a sufficient reason for teaching them how to earn money by employing it' better befits the hustings than an academic department of general practice. Argument that is casuistic and sometimes economical with intellectual honesty is the bane of debate on this issue, among all parties. We are capable of better, and our patients certainly deserve better.

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Post-viral syndrome

Sir,

The review of the post-viral syndrome by Dr Archer (May *Journal*, p.212) undoes the (minimal) progress made for reasonable treatment of myalgic encephalomyelitis patients in the last 30 years. It is absurd to write of 'a balanced view' as though such a view would be in some way reasonable because it was a fine British compromise. We are dealing with facts, and with people's lives — to talk of 'a balanced view' is unscientific and perpetuates a wholly unnecessary cruelty.

A hundred years ago there would have been no problem for myalgic encephalomyelitis patients. No laboratory tests existed and diagnoses would have had to be made on case histories and observation. Doctors would have been required to believe what their patients were (repeatedly) telling them. In fact the problem of myalgic encephalomyelitis probably did not exist a hundred years ago because it is almost certainly a man-made illness with a variety of causes including stress, pollution of all our foods and the over use of medically administered drugs. There is no reason to think that any virus implicated is other than a trigger factor to an already compromised immune system.

Until the medical profession relinquish their obsession with drug treatment, with so-called psychiatric illnesses and with laboratory testing we are unlikely to see any progress and thousands will continue to suffer unrecognized and untreated from what is clearly a physical illness.

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Sir,

While there is some merit in Dr Archer's review of the post-viral syndrome (May *Journal*, p.212) the overall effect may well be harmful since he gives some credence to the view that the illness is not organically based. Most doctors would now accept that in any illness involving the central nervous system, neurological and psychological symptoms are so inextricably mixed that they cannot easily be differentiated. Of course a sufferer from any chronic illness needs psychological support particularly if his symptoms include depression and his illness runs a relapsing course or leads to permanent disability. But I would maintain that the harm done in labelling a patient with an organic illness as hysterical far outweighs any possible damage caused by calling hysterical symptoms organic. After all, the diagnosis in early cases of multiple sclerosis is in many cases made solely on the history and in the absence of positive physical signs or abnormal tests.

I would take issue with Dr Archer's 'evidence for hysteria' on several grounds. First, cases were occurring in the general population before the Royal Free Hospital outbreak. Secondly, three epidemics have occurred among men in military barracks. Thirdly, among the neurological findings in the Middlesex Hospital epidemic which the psychiatrists attributed to overbreathing, five patients had extensor plantar responses and three had ocular paralysis with double vision. Similarly, 20% of the cases admitted to Lawn Road Infectious Diseases Unit in 1956 from north west London had extensor plantar responses.

Dr Compston and colleagues[1] have pointed out that 'while a diagnosis of hysteria had been seriously considered at the time of the outbreak, the occurrence of fever in 89%, of lymphadenopathy in 79%, of ocular palsy in 43% and of facial palsy in 19% rendered it quite untenable'.

Dr Poskanzer of the Department of Neurology at Harvard Medical School summed up my feelings when he wrote

'The articles of Drs C.P. McEveady and A.W. Beard are of considerable concern. Their erroneous conclusions about this illness may impair future investigations of similar outbreaks. It is apparent that the authors failed to do their homework and demonstrated a surprising lack of information about the principles of epidemiology and of psychiatry. It is clear that sporadic cases of this disease cannot be readily identified. It is only in the epidemic form that the distinctive epidemiological features allow characterisation. Instead of ascribing ME to mass hysteria or psychoneurosis, may I suggest that the authors consider the possibility that all psychoneurosis is a residual deficit from epidemic or sporadic cases of ME'.[2]

I would only add that modern science may well prove him right.

General practitioners who are interested in this syndrome would do well to read a recent book by A.M.Ramsey.[3]

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2. Poskanzer DC. Epidemic malaise. *Br Med J* 1970; 1: 420-421.
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Sir,

Dr Archer (May *Journal*, p.212) suggests that a balanced view of the post-viral syndrome must combine the hypotheses that it is an organic illness and that it is hysterical in nature. There is no doubt that some cases of the epidemic form are hysterical, as are some cases in any epidemic, but that is no reason to accuse sufferers with the condition of functional overlay.

The diagnosis of post-viral syndrome is made on a history of excessive muscle fatiguability with prolonged time to recovery following an acute viral illness. These patients also all complain of psychological symptoms, including tiredness, lack of concentration and poor