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Sir,

My first criticism of the paper by Wessely and colleagues (January *Journal,* p.26) is that it completely ignores the research findings showing significant abnormalities in muscle in sufferers of myalgic encephalomyelitis (ME): abnormalities in muscles fibres;[1] excessive intracellular acidosis;[2] abnormalities in muscle protein replication;[3] and virus particles in muscle tissue.[4] The authors do not appear to have read the medical literature on ME. Their failure to account for these abnormalities represents a major flaw in their hypothesis.

Even worse, the authors are clearly not listening to their patients. This patient's organization, the ME Action Campaign, does listen to its members who have repeatedly stated that where pronounced muscle fatigue is a major symptom of ME, over-exertion inevitably brings relapse. The authors of this discussion paper have ignored the patient, suspended commonsense, and embarked on a flight of fancy which may have grave consequences for their patients.

When our members come to us and say that an exercise programme has made them better, we will sit up and take notice. At present we have a growing dossier of case histories of ME patients who have had a relapse as a result of treatment of this kind. And by relapse, I do not mean a few days feeling worse — I mean up to 18 months in bed (documented case).

I regard as somewhat ironic the suggestion that, in relation to alternative therapies, 'it is a doctor's duty to protect patients from such exploitation'. We have very few reports of patients being made worse by any of these therapies — indeed many benefit from them — and the number of reports of patients relapsed by 'exercise programmes' already exceeds the sum total of complaints about these 'untested therapies'. And has the treatment being advocated by the authors been adequately tested? I think not.

It is indeed unfortunate that psychiatry, in the absence of any real answers to the problems of ME, is now resorting to the fabrication of hypotheses which are scientifically and anecodotally disproven before they have even been published, and the creation of modes of treatment which are almost guaranteed to damage many patients' chances of recovery.

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Sir,

It was our intention to write a pragmatic article to aid doctors in helping patients with severe chronic fatigue, and we have been gratified by the encouraging responses we have received. Indeed, one general practitioner wondered what all the fuss was about, as she had been using the same methods for the last two years. We remain convinced that when, as at present, the nature and aetiology of the syndrome remain the subject of scientific inquiry, there is a tendency for basic patient management to be ignored.

Professor Field takes us to task for not quoting some of the current research, although it was not our intention to review the topic. The work he cites confirms the heterogeneity of this condition.[1] For example, the reference to muscle biochemistry actually states that such findings occur in only a selected minority and have been found in different illnesses.[2] Even in normal people there is no simple relationship between muscle biochemistry and muscle fatigue.[3] Depending on technique, serological evidence of persistent viral infection appears in 7% or 45% of selected patients,[4] while virus specific protein can be detected in 26% of other selected patients.[5] The electromyographic findings[6] do not explain the clinical symptoms,[7,8] nor do immune abnormalities, which are contradictory[9] and inconsitent.[10] All such work has been performed in highly selected groups of patients, and may not reflect the position in primary care. Such findings do not yet explain the clinical syndrome, and it seems do not occur in the majority of patients seen by general practitioners.

We also believe that the principles we have delineated may be relevant to many of those both with and without such abnormalities. We do not believe there is any contradiction between the programme we have outlined and evidence of the organic nature of the condition. Such principles are identical to those used in the management of patients returning to health after a myocardial infarction.[11] They are also used in the rehabilitation of those seen in our hospital with many serious neurological disorders for which there is as yet no cure.

Professor Field's interesting historical survey serves only to highlight the origins and futility of the organic versus functional dichotomy. We have tried to steer medical thinking away from this impasse towards a more eclectic approach which takes into account the interactions between psychological, physical and social influences in the causation of disease.[12] Thankfully many general practitioners and some hospital doctors are already well aware of this. Let us reassure Mr Lev that we are not proposing exercise treatment, but rather a broadly based rehabilitation programme which, far from inevitably causing relapse has been of considerable benefit to many sufferers. The ME Action Campaign has undoubtedly increased public awareness with their powerful patient advocacy. However, their support for certain alternative treatments has often alienated them from the more established ME Association. Nevertheless, we would welcome any safe and effective treatment, whether conventional or alternative, that can help any sufferer. We hope the ME Action Campaign will adopt a similar approach, and allow much needed cooperation between self-help groups and National Health Service practitioners.

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