Sir.

The new preventive care card for use in general practice described by Drs Grundy and Dwyer goes a long way to fulfilling the requirements of such a card and in accommodating suggested alterations to earlier versions. However, we believe the lack of a flow chart showing a clear time sequence on the reverse side of the card will make it difficult to read at a glance in the years ahead as it becomes crowded with data. Also, having to write the date in each box whenever a preventive item is recorded is wasteful of nearly half the space and could mean writing the date as many as six times at one preventive consultation.

We have successfully used a preventive flow chart for nearly 12 years. Mainly for reasons of cost the flow chart is overprinted on the reverse of the current Lloyd George National Health Service immunization card (FP 7A/8A). This costs £15.50 per 1000 cards.

Space is left at the top for background information, particularly useful when using the card to monitor patients on the contraceptive pill (Figure 1). The less frequently needed rubella status is recorded on the front of the card.

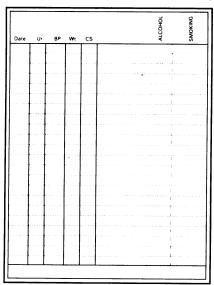


Figure 1. Preventive care card.

For many patients information on smoking and alcohol need only be intermittently recorded and the dotted line allows the doctor to write other information across these columns. There are 22 boxes in each column and even after 12 years of use scarcely any cards are running out of space. Columns for additional parameters and items such as blood urea, cholesterol and lipoproteins can be added simply by ruling more vertical lines.

A further modification of the preventive card described by Grundy and Dwyer incorporating a preventive flow chart and minor alterations to the front could provide a most useful, flexible and longerlasting card for long-term use in the NHS.

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Management of chronic (postviral) fatigue syndrome

Sir,

We were surprised that the paper on the management of chronic fatigue syndrome (January Journal, p.26) made no reference to chronic hyperventilation.^{1,2} As an essential component of effort syndrome,³ chronic hyperventilation (usually unobtrusive) is responsible for an enormous range of symptoms from paraesthesiae, palpitations and chest pain in the earlier stages of the condition to weakness and muscular disorders in the later stages. In a recent study, hyperventilation was demonstrated by capnography in 38 out of 40 patients diagnosed as suffering from the post-viral syndrome.4 Accurate diagnosis of effort syndrome allows an appropriate rehabilitative programme⁵ to be instituted. Such rehabilitation⁶ is central to cardiology, not only because effort syndrome, or Da Costa's syndrome, commonly presents to the cardiologist, but also because hypocapnia can cause coronary arterial spasm and dangerous cardiac arrhythmia under certain conditions of emotional arousal. Management based on the measured physiological disturbances should protect the patient from diversion into a pathological cul-de-sac.

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Sir.

Dr Wessely and colleagues' article may help those who have entered a viscious circle of inactivity, but what about the management of the early case and the prevention of this debilitating complication?

The prime duty of the general practitioner is the recognition of the condition, the hallmark being extreme fatiguability after exertion. Normal activities like walking across the park, upstairs or even across the room give a feeling of exhaustion and the need to rest. Normal (but in the context of the illness, excessive) exercise may lead to severe muscle pain next day that makes further exercise impossible. The imperative advice to patients is to rest (accepted as 'necessary and adaptive' by Dr Wessely but only as an illustration as to how it becomes maladaptive) and not to force themselves to continue their busy and active lives. Permission should be given to be ill and to take to their bed even if they have nothing physical to show for it. They need to be reassured that they will improve but warned that it will not be a quick process. They should be encouraged to take on extra activity gradually but they should not go shopping, out to dinner or to events unless they can leave halfway through. Holidays and trips abroad need to be arranged as for an octogenarian. Driving should be encouraged in stages but only when accompanied by a co-driver who can take over if necessary.

Profound disappointment and loss of self-confidence comes from the collapse on the knees beside the supermarket trolley or the inability to drive home. It is events such as these that lead to avoidance behaviour that is maladaptive and can lead to depression. These events often occur because of the patients' desire to act normally since their doctor may not recognize their condition and they have no signs of illness to show their family or friends. Enormous support needs to be given to help cope with the stress that this condition engenders.

The new approach encouraged by Dr Wessely and colleagues implies that