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.

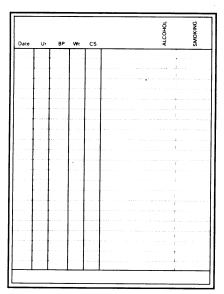


Figure 1. Preventive care card.

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

fatiguability is consistent, which it would be if it were due to loss of tolerance or poor fitness. On the contrary, exercise tolerance varies initially and the temptation is to carry on, often with disastrous consequences, especially to morale. It is the variability that is so difficult to cope with in aligning the expectations of the sufferer and the observer.

I would conclude that the advice of Dr Wessely and colleagues may be correct in some cases and is certainly helpful. However, in the early case the primary concern is recognition, rest, emotional support and gradual steady rehabilitation.

RUPERT GUDE

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Sir,

While admiring the approach of Wessely and colleagues to the management of a difficult group of patients, I do not feel the authors can apply their rehabilitative strategies to those people who genuinely suffer from the chronic fatigue syndrome.

Contrary to their statement about normality of dynamic muscle function in such patients, it has been neatly demonstrated by nuclear magnetic resonance1 that early and excessive intracellular acidosis occurs in affected muscles on exercise. It is postulated that this is due to an increase in energy production via glycolysis rather than oxidative pathways. Presumably this is the cause of the cardinal symptom of the chronic fatigue syndrome: exhaustion following moderate exercise.

Rather than suggesting that patients think 'I feel tired because I haven't been doing much lately', they should say 'I feel tired because my muscles are full of lactic acid'.

Since these biochemical abnormalities have been shown to persist for at least four years, I do not think graded exercise is going to cure them. Although the ME Association factsheet advising wheelchairs, mobility allowance and an invalid's parking permit seems nihilistic, it may be the most pragmatic approach until we can offer sufferers a decent therapeutic alternative. P.G. WEAVING

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Reference

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Sir,

My general practitioner has drawn my attention to the paper by Wessely and colleagues. As someone who has been suffering from post-viral fatigue syndrome for the past year, I welcome the publication of anything which may help in the management of this wretchedly debilitating syndrome. However, I feel horrified by the authors' suggestion that doctors should encourage patients suffering from post-viral fatigue syndrome to undertake exercise even when patients are convinced that this makes their condition worse. It is of course probable that some people believing themselves to be suffering from post-viral fatigue syndrome may be unnecessarily and even detrimentally constraining their activities. But for many sufferers even very small amounts of activity are likely to worsen the symptoms and to lengthen the time it takes to reach recovery, particularly when the syndrome is in its early stages (which can last up to two years or more) and when the sufferer is in relapse.

As the authors acknowledge, little has so far been written about the treatment of the syndrome in the medical literature, but they appear lamentably unaware that a considerable amount has nonetheless been produced by a number of people with extensive experience of the syndrome and its management, such as the ME Association, Ho-Yen¹ and Wilkinson.² Everything I have read emphasizes that it has been found essential for sufferers to learn to recognize their limitations, and to exercise the self-discipline necessary to live within them.

This advice reflects my own experience. I benefitted from an early diagnosis and a sympathetic general practitioner, and felt able from the outset to accept that with the current state of medical knowledge the medical profession has little to offer other than diagnosis and symptomatic relief. I found that I had to take responsibility for the management of my illness (the approach that I subsequently found to be advocated by Ho-Yen), and I have now become reasonably expert in it. The symptoms fluctuate greatly and initially I failed to accept that I was ill and to make appropriate adjustments to my lifestyle - in which work and mountaineering were then the dominant passions. However, I then faced up to the fact that I was obliged to make getting better the first priority in my life. Now, a year later. I have made a lot of progress and have managed to return to full-, time work — but only by rigidly avoiding excess exercise or other activity. What constitutes 'excess' varies enormously. I continue to be vulnerable to relapses, and at such times walking 50 yards is without question deleterious. At good times

however — for example, towards the end of a week's holiday — I can manage a sixmile walk (providing it is on easy terrain). I have learnt to judge what I can manage at any time. My judgement is not perfect and I still overdo it, and that makes me feel unwell for up to two weeks. Going beyond what I recognize to be sensible, in the rare circumstances when it is unavoidable, leads to a full relapse. None of the effects of over-activity are pleasant, so I tend to be cautious — sometimes, no doubt, over-cautious. But I am convinced that curtailment of activity has been a quintessential ingredient of my recovery to date, and that its continuation will be essential to my hopes of eventual recovery.

I have the good fortune to be welleducated, articulate and self-confident; to have suffered post-viral fatigue syndrome to only a relatively mild degree; to have been able to come to terms with my illness quite quickly; and to have a good relationship with my general practitioner as well as the support of my partner and family. What worries me greatly is that other sufferers in less favourable circumstances will be less able to make and to stick by their own decisions about their illness. Such people may be persuaded by their medical practitioner, against their own better iudgement, to increase their activity levels and suffer what could be great damage.

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- 2. Wilkinson S. ME and you: a survivor's guide to post-viral fatigue syndrome. Wellingborough: Thorsons, 1988.

Corrigendum — A sentence in Professor Field's letter about the chronic fatigue syndrome in the April issue (p.171) should have read 'Incidentally, about 40% of families ... show more than one case in the family' and not 80%.

Role of the community pharmacist

The paper by Dr Roberts (December Journal, p.563) displays an almost complete misunderstanding of the role of the community pharmacist. It reveals a touching faith in the infallibility of computers. about health education of patients by doctors and about the takeover of various community duties by other members of the primary care team.

I should like to broaden the debate by discussing it in more sociological terms.