The 75 patients comprised: 27 with probable or definite rheumatoid arthritis; 32 with osteoarthritis; 16 with other disorders (including three with possible rheumatoid arthritis). There was no evidence of a large number of cases attending their general practitioners with very mild rheumatoid disease. Most patients were elderly (mean age 65 years); 12 patients were over 80 years. The majority were women (m:f 15:60).

Many patients had considerable functional impairment assessed by Steinbroker functional classes.[1] Over 70% were severely incapacitated or housebound. Osteoarthritis was the most frequent cause of such severe disability and it usually involved the hip in these cases. The osteoarthritis was often longstanding and the patients elderly. There was a direct relationship between functional impairment and age in all diagnostic groups.

Despite functional impairment only 31% of cases were attending rheumatology clinics and 17% orthopaedic clinics. Only five (25%) of the housebound patients attended rheumatology clinics and none were going to an orthopaedic clinic. More of the 27 patients with rheumatoid arthritis were seeing a rheumatologist than patients with other conditions and 15 (56%) were current clinic attenders. These clinic attenders were slightly younger and more often men (Table 1). The functional classes of the rheumatoid arthritis patients were similar whether or not they attended a rheumatology clinic.

Community support was received by 63% of the patients. The most widely used support was a home help in 29% of cases. Other support groups visited less frequently including physiotherapists in 27% of cases and occupational therapists in 21%. A minority of patients (32%) were registered as disabled.

This preliminary survey shows that many patients had considerable functional impairment owing to arthritis yet only a minority attended hospital clinics to see rheumatologists or orthopaedic surgeons. It would help general practitioners if there were agreed criteria for hospital referral, and clearer objectives to be gained from attending a specialist clinic.

We found considerable differences between rheumatoid arthritis patients attending and those not attending rheumatology clinics. The clinic attenders were more likely to have received slow acting anti-rheumatic drugs and corticosteroids, but functional capacities were similar in non-attenders and attenders. Recent studies of the outcome of hospital treatment for patients with rheumatoid arthritis casts doubt on the long term impact of slow acting anti-rheumatic drugs[2] and the results of this community survey support such a view. The precise role of outpatient rheumatology clinics in the long term management of rheumatoid arthritis needs further definition.

Table 1. Patients with rheumatoid arthritis: comparison of those attending and not attending rheumatology clinic.

	Attending clinic ($n=15$)	Not attending clinic ($n=12$)	All patients ($n=27$)
Mean age (years)	58	65	61
Mean disease duration (years)	9	8	9
Male:female (numbers)	6:9	1:11	7:20
Functional classes			
Mild impairment	5	4	9
Marked impairment (off work)	7	6	13
Severe impairment (housebound)	3	2	5
Drug therapy			
Slow acting drugs	5	0	5
Corticosteroids	8	1	9

n = total number of patients

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Management of the post-viral fatigue syndrome

Sir,

We read with interest Dr Ho-Yen's thoughtful paper on the management of the post-viral fatigue syndrome (January *Journal*, p.37) and welcome the renewed interest in practical management. Dr Ho-Yen's article is written in response to our previous paper on the subject,[1] and although there are differences between the two approaches, we must first point out the considerable areas of agreement between us, perhaps no more so than the emphasis on the role of the general practitioner, and of the crucial importance of a healthy doctor–patient relationship.

Many of the apparent differences between our approach and that of Dr Ho-Yen are, as he states, due to sample differences. Our experience is based on patients with chronic illness seen in specialist neurological settings with a mean illness duration of five years.[2] Dr Ho-Yen is familiar with patients with shorter illness durations, referred for a microbiological opinion. Many of the strategies advocated by Dr Ho-Yen are therefore designed for those in whom spontaneous recovery can still be anticipated. However, what about when such recovery has not occurred? In the two largest samples to date others have noted 'an alarming tendency to chronicity',[3] and it has been alleged that 'most of the cases seen do not improve, give up their work and become permanent invalids'.[4] The current therapeutic approach for these patients is obviously unsatisfactory.

How does such chronicity develop? Dr Ho-Yen criticizes the first stage of the model we proposed to explain such chronicity, and points out that far from initially adopting forced inactivity after a viral infection, many chronic sufferers did the opposite, and tried to exercise away the fatigue. We accept his observation. Dr Ho-Yen's comments do indeed coincide with our own clinical impressions: many patients report initially adopting such strategies, and find that these are unsatisfactory, leading to a rapid recurrence of symptoms. However, we suggest this is an even more convincing explanation of the remainder of the model we propose. Simple operant conditioning suggests that such a powerful experience of failure will lead to persistent avoidance, perhaps when the original need for it is no longer present. We also suggest that early and repeated exposure to uncontrollable, aversive and mysterious symptoms, such as the profound muscle pain that characterizes the syndrome, is another potent cause of the demoralization and helplessness so frequently found (Powell R, Wessely S, manuscript submitted for publication) and may in turn explain the high rates of mood disorder that have been observed in several studies.

We do, however, disagree that the management we advocate is to 'get out and exercise'. This is a common misconception. Cognitive behavioural therapy is not exercise therapy, and we are not physiotherapists. It is true that in the later stages of treatment patients are encouraged to increase their activity (which must ultimately be the aim of any treatment) but therapy does not involve the simple prescription of set amounts of exercise. Instead, treatment is based on mutually agreed targets, which are themselves jointly chosen as being some activity that the patient wishes to undertake, but has avoided. In practice this may simply be brushing one's teeth, or sitting out of bed to eat a meal. The behaviour is chosen solely on the basis of avoidance; the physiological and ergonomic consequences of such activity are irrelevant. The aim is to introduce predictability, and the return of self-control and self efficacy, not to restore muscle power. Furthermore, the other important component of our approach to management is an awareness of emotional disorders, and a recognition that these may need treatment in their own right.

We agree that the management we advocate is neither new nor unique. Almost identical management is now the treatment of choice for chronic pain[5] and fibromyalgia.[6] The latter is particularly relevant, since it is increasingly accepted that fibromyalgia may indeed be the same condition as post-viral fatigue.[7] Furthermore, it is difficult to think of a pathological mechanism by which gradual increased activity could be harmful,[8,9] even in the minority of patients with clear cut neuromuscular pathology.

The final decision must be based on evidence. We have already announced preliminary details of a pilot evaluation of cognitive behavioural therapy (Wessely S, *et al,* abstract presented at the scientific meeting of the Royal College of Psychiatrists, London, 25 September 1989). Our conclusion was that the advice currently offered to these patients may not be accurate, and that the current therapeutic nihilism in this condition may be unduly pessimistic.

In summary, the differences between our approach and that of Dr Ho-Yen may be less marked than at first sight. Given the difference in our samples and clinical experience, one might summarize by saying that whereas Dr Ho-Yen correctly emphasizes the dangers of doing too much, too early in the natural history of the condition, we emphasize the equally damaging consequences of doing too little, too late. The most appropriate strategy depends upon the stage of the illness reached by the patient.

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Advising patients on their benzodiazepine use

Sir,

We read with interest the paper by Cormack and colleagues (October *Journal,* p.408) on the subject of advising patients on their benzodiazepine use. We have obtained comparable results from a similar, but not identical, study which we have just completed. In our prospective study in an inner city practice of 12 100 patients we identified 46 patients (0.4%) who were receiving benzodiazepines on repeat prescriptions. All were long-term users, the mean duration of use being 14 years (range three to 21 years), and they were an older group than that studied by Cormack and colleagues with a mean age of 62 years (range 30 to 89 years).

In their paper Cormack and colleagues noted that strategies used by patients to reduce benzodiazepine consumption were 'vague and unsophisticated'. We offered a simple programme to all our patients. Intervention consisted initially of ceasing all repeat prescribing of benzodiazepines and instituting regular consultations for all those individuals wanting such medicines. At these consultations the patients were given verbal and written information about the known risks of long-term benzodiazepine use, and were offered a phased withdrawal programme involving dose reduction, reduced frequency of use and reduction in preparation potency, prior to cessation of all use. Progress was reviewed at subsequent consultations, and counselling support was offered within the practice (by practice counsellors) and outside the practice (in health authority clinics), although no patients took advantage of these options. Therefore, this strategy, while involving extra consultation time and the preparation of simple written material, used only resources available to all general practitioners.

One year after this intervention, six of the 46 patients (13.0%) had stopped all benzodiazepine use, 22 (47.8%) had reduced their consumption and 14 (30.4%) had not changed their pattern of use. No patients had increased benzodiazepine use, but two had left the practice and two had died.

Although this intervention was applied to an elderly subpopulation that we presumed would resist reduction of their benzodiazepine use, the success in changing habits was greater than anticipated. The assumption that such patients are 'hopeless addicts' appears unfounded. Formal challenge, the provision of verbal and written information and regular follow-up consultations seems a clear and effective strategy for approaching the problem of long-term dependency.

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Traveller gypsies

Sir,

I read with interest the recent review article on traveller gypsies and primary care (October *Journal,* p.425). While it covered many of the issues about travellers and health care, there are several further points that I would like to raise.

First, the review suggests that epidemics of infectious diseases have not been documented among the traveller popula-