

## CHRONIC DISEASE MANAGEMENT – CHRONIC FATIGUE SYNDROME

Sir, I have delayed in writing to you on the subject of the above paper in the hope that my shock and anger would dissipate with time. However, I feel compelled to register my complaint that a paper running to some 11 pages which comprised anecdotal evidence and subjective observation of no scientific validity could be published in what I presume to be a peer reviewed journal.

I venture to suggest that had the principal author not been Head of Communications and Publishing for the Royal College of Physicians of Edinburgh this paper would never have seen the light of day except in a lay magazine such as the *Reader's Digest* or *The Sunday Post*. What on earth are your readers supposed to have learned from reading this article? That mainstream doctors are generally unsympathetic and prejudiced when it comes to dealing with syndromic illnesses? That patients with chronic fatigue feel that they are suffering from an organic disorder when in most instances there is strong evidence to the contrary? I wonder if *The Journal* has plans for a series of such anecdotal papers related to other contentious areas of medicine such as pelvic pain without pathology or irritable bowel syndrome. No one denies that these syndromic illnesses pose difficult problems for patient and doctor alike, but to give 11 pages of a scientific journal to an individual's personal experiences as opposed to a randomised control trial or extensive review of the literature seems entirely inappropriate.

For all Mr McAlister's protestations to the contrary, chronic fatigue disorders behave more like psychiatric illnesses than structural organic pathologies and his personal experiences do not change the known epidemiology of fatigue.

**P.A. REILLY**

## REFERENCES

- 1 McAlister G, McPartlin G. Chronic disease management – chronic fatigue syndrome. *J R Coll Physicians Edinb* 2002; **32**: 122–33.

## REPLY

Sir, regarding Dr Reilly's letter.<sup>1</sup> Whilst a considerable number of scientific papers have been published on chronic fatigue syndrome (CFS) over the last decade, and two major reviews of the literature have been published<sup>2,3</sup> since the paper which I co-authored<sup>4</sup> was submitted for publication, great uncertainty still exists regarding the aetiology, treatment and classification of CFS. The application of evidence based medicine (EBM) in the context of CFS is, therefore, limited and practical treatment difficulties can ensue for clinicians and patients alike while waiting for the state of evidence to evolve.

Against this background it was decided to write a paper

which would seek to enhance the existing evidence base by informing a general medical audience about the *practical* difficulties involved for both clinicians and patients in treating CFS. By presenting parallel perspectives from a patient and a GP (and thus enhancing the educational value of the paper) the paper did not seek to duplicate ongoing attempts to review the quantitative research literature on CFS but, instead, to increase medical understanding by adding to the growing qualitative research base on this area. In seeking to add to this evidence base, and to reach such a general medical audience, I trust that Dr Reilly will share my view that it made more sense to submit this paper to a peer reviewed medical journal rather than one of the lay media outlets suggested (which would have fallen outwith the target audience and *raison d'être* of the paper).

In a related development readers of *The Journal* may be interested to know that a variety of UK based organisations concerned with the promotion and practical use of EBM, such as the National Institute for Clinical Excellence (NICE), the Health Technology Board for Scotland (HTBS) and the Scottish Intercollegiate Guidelines Network (SIGN) (which the College was instrumental in establishing and with which the College is still closely involved) are all currently looking at ways in which their respective methodologies might be adapted so as to permit the inclusion of both qualitative and quantitative literature in future reviews. This work is being carried out in recognition of the fact that the inclusion of qualitative literature will enhance the evidence base beneath, and the treatment of, a variety of clinical conditions. Similarly, in making the distinction between quantitative and qualitative literature, and in seeking to add to the evidence base by publishing both of these different styles of paper, the Editor of *The Journal* should be commended rather than condemned for his actions.

The paper, as published, presented objective reporting of the authors' experiences in dealing with CFS and recognised the polarised attitudes which unfortunately exist regarding its aetiology, treatment and classification. In seeking to attempt to begin to reconcile these polarised attitudes, rather than perpetuate them, the paper did not, despite Dr Reilly's assertion, presume to make 'protestations' regarding the organic or non-organic nature of an illness for which the aetiology is still unknown.

The paper was submitted to *The Journal* in line with normal publication procedures and I would strongly refute any implied impropriety regarding its publication. Had the paper been considered to be inappropriate or substandard it would, quite simply, not have passed the clinical editorial process.

**G. MCALISTER**

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- 2 NHS Centre for Reviews and Dissemination. Interventions for the management of CFS/ME. *NHS Centre for Reviews and Dissemination Effective Health Care Bulletin* 2002; **7**:4.
- 3 Royal Australasian College of Physicians. Chronic Fatigue Syndrome – clinical practice guidelines. *Med J Aust* 2002; **176**(Suppl):S17–S55.
- 4 McAlister G, McPartlin G. Chronic disease management – chronic fatigue syndrome. *J R Coll Physicians Edinb* 2002; **32**:122–33.

## NOTE FROM THE EDITOR

Dr Reilly should be assured that all papers submitted for publication in *The Journal* are subject to peer review, and to editorial comment and change, prior to publication, whosoever sends them and wherever they are sent from. The article in question was similarly vetted.

## QUEEN MOTHER'S VISIT

Sir, May I offer a postscript to Professor Michael Oliver's letter about the Queen Mother's visit to the College?<sup>1</sup>

First, the (then) President mentioned to me that he asked the Equerry who did the recce before Her Majesty paid her visit at what rate she would walk up the stairs. The answer came: 'At the same rate as you, sir.' Second, it was noticeable that Queen Elizabeth the Queen Mother read her speech of formal opening without the need for spectacles. Third, as Professor Oliver noted, The Queen Mother stayed 40 minutes longer than planned. One of the invited guests, near whom I was standing, said 'Will Your Majesty not be in danger of missing your plane?'. The answer, given very sweetly, was 'Oh, no. It always waits for me'.

W.K. REID

## REFERENCES

- 1 Oliver MF. Queen Mother's visit. *J R Coll Physicians Edinb* 2002; **32**:226–7.

## COSIMO DI MEDICI'S ARTHRITIS: MEDICINE, ART AND RELIGION

Sir, The paper on Cosimo di Medici's arthritis and his portrait illustrates an interesting link between medicine and art.<sup>1</sup> The subject also gives an opportunity to explore a historical, intertwining relationship between medicine, art and religion. The family name Medici was the Latin (and Italian) word for physician, and the Christian name Cosimo was the Italian for Cosmas.<sup>2</sup> Saints Cosmas and Damian, twin brothers, were recognised as the patron saints of medicine and doctors.<sup>2–5</sup> Cosimo di Medici was especially devoted to these two saints because his son and heir, Piero il Gottoso (the Gouty) was chronically ill

and constantly needed a physician's attention.<sup>2–5</sup> In fact, Cosimo di Medici commissioned many great artists of the period, including Fra Angelico, or Painter of Angels (Giovanni de Fiesole, 1400–1455), and Rogier van der Weyden (1399/1400–1464), to create paintings depicting the two saints.<sup>2–5</sup> In modern times, the Catholic Association of Doctors of Medicine in Great Britain bears the title The Guild of St Luke, St Cosmas and St Damian.<sup>3</sup> These latter two saints were also incorporated as supporters in the coat of arms of the Royal Society of Medicine, London, granted in 1907.<sup>3,5</sup>

J.K.T. NGEH AND V.K.L. TOH

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- 1 Strauss RM, Marzo-Ortega H. Cosimo Di Medici's Arthritis. *J R Coll Physicians Edinb* 2002; **32**:212–13.
- 2 Danilevicius Z. SS Cosmas and Damian, the Patron Saints of Medicine in Art. *JAMA* 1967; **201**:1021–5.
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- 5 Peltier LF. Patron Saints of Medicine. *Clinical Orthopaedics and Related Research* 1997; **334**:374–9.

## INCREASING BODY WEIGHT

Sir, it is generally accepted that on average world population weight is increasing, and this applies particularly to Western countries.

I have previously published two papers in your journal, one relating to body mass index (BMI) in 1989–91<sup>1</sup> and the other to waist-hip ratios (W/H) in 1993–5,<sup>2</sup> and therefore I have data for both these indices for these dates. I now also have collected data for 1999–2001. All these data came from life assurance candidates.

The Department of Health (DOH) has published tables for BMI for 1991–2000 and for W/H for 1993–8.<sup>3</sup> Unfortunately, there are no DOH data for the BMI before 1991 or after 2000, and for W/H none before 1993 or after 1998; however, comparisons are still interesting.

The DOH and my data are shown in Table I, and indicate that, unfortunately, the chronology of the two sets is not exactly the same. The data collected by myself show that for men BMI levels have increased by 6.3% in ten years ( $p < 0.001$ ), and the DOH by 4.7% ( $p < 0.001$ ) in nine years. For women the ten year BMI increase is 12.8% ( $p = 0.005$ ) (my data; the DOH data for nine years are 4.7% ( $p < 0.001$ )). For W/H from 1994 to 2000 my data indicate an increase of 2.2% for men ( $p < 0.001$ ) and 7.2% for women ( $p < 0.001$ ), and the DOH from 1993 to 1998 an increase of 1.1% for men ( $p < 0.001$ ) and 1.3% for women ( $p < 0.001$ ). The differences between these two sets of data for W/H were all significant: 1993–4

**TABLE 1**  
Body mass indexes and waist-hip ratios at various dates, from data by the author and DOH.

CDRP data*						DOH data					
Dates	BMI mean	SD	W/H mean	SD	N	Dates	BMI mean	SD	W/H mean	SD	N
<b>Men</b>						<b>Men</b>					
1989-91	25.5	3.60	-	-	231	1991	25.6	4.07	-	-	1,372
1993-5	-	-	0.92	0.048	138	1993	-	-	0.90	0.08	6,488
1999-2001	27.0	4.87	0.94	0.053	166	1998	-	-	0.91	0.08	7,193
Increase %	5.90	-	2.2	-	-	2000	26.8	4.57	-	-	3,260
<b>Women</b>						<b>Women</b>					
1989-91	24.2	4.90	-	-	86	1991	25.4	5.48	-	-	1,531
1993-5	-	-	0.83	0.073	39	1993	-	-	0.79	0.08	7,142
1999-2001	27.3	6.49	0.89	0.063	34	1998	-	-	0.80	0.09	8,715
Increase %	12.8	-	7.2	-	-	2000	26.6	5.48	-	-	3,703
* Author data						Increase % 4.7 - 1.1 - -					

men  $p = 0.003$ , women  $p < 0.001$ ; 1998-2000 men  $p = 0.002$ , women  $p = < 0.001$ .

For BMI the differences were not significant, except for women in 1990-1 when significance was just reached ( $p = 0.047$ ). For all the other differences  $p$  was greater than 0.4.

No convincing evidence of significant differences exists between my BMI data and those of the DOH despite the larger percentage increase in mine. However, had my numbers (N) been over 6,000 for men and over 300 for women, and the standard deviations and means remained the same, significances ( $p = 0.05$ ) would be reached.

It is probable that some of my life assurance subjects have been sent for medical examination because they are known to be or suspected of being overweight or obese, which may have somewhat confounded the data.

**C.D.R. PENGELLY**

#### ACKNOWLEDGEMENTS

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- 3 Health Surveys for England. Department of Health. [www.doh.gov.uk/stats/trends/.htm](http://www.doh.gov.uk/stats/trends/.htm) June 2002.

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