COLLEGE LITERATURE

Gillian Cloke, who works in the Administration office of the College, has just had published a book; *This Female Man of God: Women and spiritual power in the patristic age, AD 350–450* (Routledge, London and New York 1995 pp. 11+243) £12.99 (paperback)

Soon after the conversion of Constantine to Christianity in 312, Christianity unexpectedly became the dominant religion of the Empire. With freedom from persecution Christians could assemble for councils, and different churches and sects were founded and maintained by enthusiasts (see *Proceedings* 1994; **24:** 161–4). Among these were the Ascetics, holy men who lived alone in the deserts or caves in mountains in Syria. This book gives an account of their female counterparts with chapters on pious Virgins (wise ones and weaker vessels), widows, married sanctity, and Christian motherhood. None of these holy women left any writing but in their lifestyle and fervour they inspired and encouraged writings of the Christian fathers, notably St Augustine and St Jerome. From them we know that some of these women of God were able to adjust to an apparently unnatural life of celibacy and become a force in the life of their church. Much less is known about those who failed.

This book, abstracted from the patristic literature, gives an interesting account of the extreme asceticism that seems to us today a strange perversion. There are still today Christian cults similarly inspired, some of which in the USA have been led by psychopaths with tragic results. Gillian Cloke is an historian and she sticks to her last; there is little of the psychology of self-denial (perhaps one should go to C. G. Jung for this); there is, however, some fascinating detail of the weird and wonderful theories of the time on the physiology of women. She also presents some of the historical background to the present controversy as to whether or not women should be ordained priests. This is a solid book that holds the interest of a general reader.

R.P.

Letters to the Editor

CHRONIC FATIGUE SYNDROME

Sir, We enjoyed reading Dr Leitch's comprehensive *tour d'horizon* (*Proceedings*, 1994; **24:** 480–508).

He touched on the condition as it affects children; temporary periods of fatigue are probably more common than we suspect and may occur in patients as young as their second year of life. We have seen toddlers experiencing several months of unusual tiredness, often accompanied by reluctance to eat. This anorexia may be thought behavioural (and indeed may continue after recovery from malaise) but could also be caused by changes in taste sensation which many older children complain of. We have had one such patient who was considered initially to have anorexia nervosa. Although children in the adolescent years and earlier may develop a conversion syndrome—which again we have seen—most do find the impact of fatigue on their lives frustrating and burdensome. Younger children, of course, are often unable to describe how they feel and their symptoms may be misinterpreted. The condition has a serious impact on schooling with many requests for home tuition and for recognition by examination authorities that the candidate may have been at a disadvantage because of ill health.

As in adulthood we try to keep investigations to the minimum but we recognise that the differential diagnosis is different.

We too have been interested in patients with fatigue following Glandular Fever. We wonder if early treatment such as with corticosteroid therapy[1] might change its course and we are considering an intervention study.

Incidentally we wonder if Anthony Trollope gave an early description of the syndrome when he described the plight of Anty Lynch in his novel *The Kellys and the O'Kellys*.

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Sir, I read with great interest the recent review of the Chronic Fatigue Syndrome (*Proceedings* 1994; **24:** 480–508). In my osteopathy practice I see a great number of patients complaining of chronic back pain and encounter many problems with uncertain diagnosis and a plethora of seemingly unrelated symptoms. I believe that the modern pain literature is helpful in understanding these problems, particularly Wall's work on the neuromatrix as being the 'body self' and how perturbation of the neurosignature can become self perpetuating and influence not only the perception of health, but also its physical expression.

My purpose in writing is to report an experience which may indicate a possible avenue for future research. During the last five years I have encountered three people suffering from chronic fatigue who appear to have been 'cured'

almost instantly by severe pain. The first of these was a teenage girl who recovered after breaking her wrist. I always considered her rather 'precious' and dismissed the observation, but later I saw and treated a medical colleague for neck pain; this lady had suffered from chronic post-viral fatigue for several years but had nonetheless continued with her career and had remarried and remained very active despite her disability but at considerable cost. She then had a ruptured appendix and within a few days, despite the pain and post-surgical state, knew that her fatigue had resolved. The third case also concerns a doctor who had suffered fatigue for two years until she burnt herself on the palm of the hand, again with rapid resolution of the fatigue.

I hope that these observations might encourage others, with a more direct involvement in this condition, to look for similar events in their own patients. And if this appears to be a regular occurrence it may help in the understanding and even, possibly, the treatment of this intriguing disorder.

M. Pickin
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Sir, I am prompted to write after reading Dr Sim's comments[1] on Dr Leitch's thorough and discompassionate review of chronic fatigue syndrome (CFS)[2] Dr Leitch's review was of particular interest because he is neither psychiatrist, infectious disease specialist nor rheumatologist.

Regrettably, the notion that CFS belies an underlying depressive illness with a secondary gain component is common[3,4] I developed CFS in late 1990 after an acute gastro-intestinal infection. Profound fatigue and fibromyalgia were dominant symptoms. Sleep was plentiful but characteristically non-refreshing. Neither I nor my physicians felt I was depressed. Modest doses of amitryptilene helped the pain and stiffness of fibromyalgia, but full doses had no effect on the global fatigue.

With good health and a secure income, it is difficult to conceive how one might react to sudden loss of all income, with little idea when one might be able to work again. Naturally, I turned to the insurance company holding my disability policy, premiums for which had been faithfully deducted from income over the years. However, disability and its accruing benefits are assessed and disbursed by representatives of one and the same company, after reports from appropriate physicians. The companies have made public their 'hostile' attitudes to CFS patients.[5] I was subjected to more mental anguish by my insurance company than by the illness.

Dr Sim's stereotyping of CFS sufferers are mostly disabled individuals seeking insured benefits is unwarranted, and indicates a lack of impartiality as consultant to an insurance company. Even if the 'real' diagnosis were depression, it should be insurable, provided one is appropriately disabled. Insurance companies who refuse to provide benefits to disabled CFS patients are sending a clear message of disbelief, ie they consider the patient to be malingering. Fortunately, I was able to articulate my views and provide supportive literature to the company which, at one point, terminated benefits. They would not support a graduated return to work until I successfully contested the issue. I wonder how less informed patients might have fared.

The patient is caught in the middle of the debate on aetiology of CFS. Fortunately, the Centre for Disease Control (United States) has acknowledged that CFS is a real and non-imaginary illness.[6] The World Health Organisation has also joined the believers.[7] Cynical views of secondary gain amongst CFS patients should be dispelled. No further anecdotal opinions on CFS and its sufferers are needed. These should be challenged.[8] I would add sensitivity and open-mindedness to the context in which Dr Leitch suggests CFS be managed. Further research is underway, from which it is hoped that there will be conclusive evidence on aetiology, and thence effective treatment.[9]

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CETACEAN STRANDINGS AND PLANKTON TOXINS

Sir, Whales, dolphins and porpoises (cetaceans) have ben recorded as stranding world wide since ancient times. Aristotle[1] recorded this behaviour and said 'that it was without any motive whatever'. This phenomenon has been observed on the coasts of Scotland and northern England and was studied by Sir Robert Sibbald[2] one of the founders of the College, who published a book on the subject in 1692, a copy of which is in the library of the College. Reports on the stranding of cetacea have been kept for the British Isles since 1913.

A second phenomenon of fish and shellfish poisoning due to dinoflagellate toxin in the plankton also occurs from time to time on our coastline, and since 1968, when it was first monitored, announcements are made on radio and TV banning the sale of shellfish for a period, usually in the summer months. I became interested in these phenomena when I was the British Medical Officer in the Anglo-French Condominium of the New Hebrides, now Vanuatu. The sight of whales breaching in the open Pacific is unforgettable. To be poisoned by eating fresh and apparently healthy fish was also a memorable experience and resulted in my writing a paper on the subject.[3] In 1988 a colleague and I wrote a paper on 'Pelagic Paralysis'[4] which summarised existing information on the fish toxins; tetrodotoxin, saxitoxin (Paralytic shellfish poisoning) and ciguatoxin. It occurred to me that the phenomenon of cetacean strandings and the presence of toxic plankton in the sea may be related. The poisoning and death of whales and dolphins by dinoflagellate toxins was reported. It might be that toxic plankton passing through the food chain of the cetaceans caused neurotoxic effects which could account for stranding. I tested this hypothesis by correlating the records of cetaceans stranded along the coasts of Scotland and northern England from the

Moray Firth to the river Humber with those of paralytic shellfish poisoning (PSP) in mussels and other shellfish over the same stretch of coastline because this is the only area in Britain, and, possibly in the world, where monitoring of both events has been carried out systematically since an important outbreak of PSP occurred in 1968.

Completed data of stranding (site, numbers, species, dates) and the results of the toxicity were collected for the periods 1971–77 and 1981–86. Out of 123 strandings only 6 (4·8 per cent), however occurred in the areas of high PSP. It is evident therefore that cetaceans do not strand more frequently in the areas of high toxicity nor at times when high toxicity is recorded.

I have lodged with the college Librarian the detailed data of the study so that material should be available to others working in these areas in the future.

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MANAGEMENT OF HYPERGLYCAEMIC EMERGENCIES

Sir, Reviews of the management of diabetic metabolic derangements such as the recent College Symposium,[1] often fail to take cognisance of the full implications of management of the co-existence of diabetic decompensation and left ventricular failure (LVF), a common aetiology being myocardial infarction giving rise to metabolic as well as cardiac decompensation. In a personal series of 29 episodes of diabetic decompensation in 28 patients successfully treated with the low-dose intravenous insulin infusion regime, there were 7 such cases (Table 1). The latter included a 91 year old woman admitted with the following biochemical parameters: serum sodium = 134 mmol/l, potassium = 4·2 mmol/l, urea = 10·4 mmol/l, glucose = 50·6 mmol/l, bicarbonate = 16 mmol/l, serum osmolality = 337 mOsm/kg. She did not receive intravenous fluid replacement, but was managed with intravenous infusion on its own, with consequent biochemical improvement as follows: serum sodium = 143 mmol/l, potassium = 3·2 mmol/l, urea = 13·1 mmol/l, glucose = 11·0 mmol/l, bicarbonate = 27 mmol/l, osmolality = 310 mOsm/kg. Her cardiac failure was successfully managed with diuretics. Similar measures were taken in all but one of the 7 patients with co-existing diabetic decompensation and LVF cited in Table 1. In the only patient to receive cautious intravenous fluid replacement despite co-existing LVF, metabolic and clinical responses were erratic, although the final outcome was favourable. For these reason, the issue of cautious fluid replacement[2] vs metabolic correction without recourse to intravenous fluids,[3,4] will need to be addressed by a fully fledged controlled trial.

TABLE 1

22 episodes in 21 patients with no evidence of heart failure

	Age (years)	*Sodium (mmol/l)*	*Potassium (mmol/l)*	*Urea (mmol/l)*	*Glucose (mmol/l)*	*Calculated serum osmolality (mOsm/kg)*
Mean pretreatment values	79·5	134	5·0	28·7	40·3	346·4
Range	72–89	116–153	3·9–6·8	6·4–58	30·7–53·3	312–404
Seven out of twenty-two instances of serum bicarbonate <22·0 mmol/l						
Mean post treatment values		138	4·4	8·55	9·0	303·2
Range		133–144	3·3–5·5	5–17	2·9–16·8	291–316·8
7 episodes in 7 patients with heart failure on admission						
Mean pretreatment values	83	133	4·8	10·8	37·6	324
Range	76–91	128–136	4–5·7	4·5–17·2	30·2–50·6	311–337
Four out of seven patients had serum bicarbonate <22·0 mmol/l						
Mean post treatment values		139	3·8	11·0	10·1	305
Range		133–143	3·2–4·3	6·3–15·4	8·2–11·4	299–316

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AUTHOR'S REPLY

Sir, I read with interest the letter of Dr Jolobe. He makes an important contribution to the debate on the use of fluids in the treatment of hyperglycaemic emergencies. It should be made clear that his patients were all elderly (age 79–91 years), and were largely non-ketotic hyperglycaemic. Of particular importance is that those with heart failure on admission were only mildly hyperosmolar. Dr Jolobe advocates omission of IV fluids in 6 such patients, reporting good recovery.

In our article in the *Proceedings*, we recommended 'more cautious fluid replacement than has previously been recommended . . . particularly in the elderly'. I feel uneasy about withholding fluid in the severely dehydrated decompensated patients and would prefer to use fluids, albeit cautiously, guided by central venous pressure replacement. Tissue perfusion, hypotension and hypovolaemia all require attention if insulin is to function properly. If a patient is neither dehydrated nor hypotensive then the Jolobe approach could perhaps be used. A trial may indeed be warranted, but in the meanwhile I shall continue cautious rehydration!

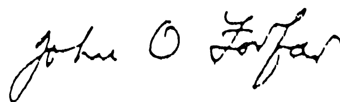
K. G. M. M. Alberti
The Medical School, University of Newcastle upon Tyne

THE BATTLE FOR PORT-EN-BESSIN 6–8 JUNE 1944

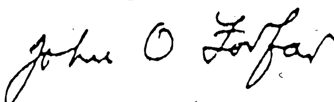
Sir, John Forfar's thrilling account (*Proceedings* 1994; **24:** 218–46) describes the successful assault by 47th Royal Marine Commando of this vital strong point

situated between the British and American landings. The port was so heavily fortified that it was necessary for the commandos to attack from the rear rather than from the sea but in doing so suffered heavy casualties.

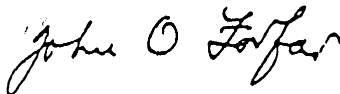
This article recalls to me an incident occurring mid-morning on 6th June 1944 (D-Day), on Juno Mike Red beach, near Coursełles. Personnel from No. 2 FDS (Field Dressing Station) in which I served had just landed with the task of establishing a field dressing station and CEP (Casualty Evacuation Point) in the village hall at Graye-sur-Mer, some five-hundred yards from the beach. Due to enemy resistance over the dunes it was not possible to leave the beach, so assistance was given at the BDS (Beach Dressing Station) part of the same unit, which had landed much earlier at 0800 (H+15 minutes) to deal with the casualties on the initial assault. Two of the wounded seen at the time were Royal Marine Commandos and it was observed that their casualty documents had been completed in very neat writing over the slim squiggly signature:



As there were no formal lines of evacuation established at that time, these casualties, after review, were placed on an LCT (Landing Craft Tank) returning to Portsmouth. During the next day or two, further Royal Marines came through the unit each with fully documented medical records signed:



Very favourable comments were made about the details provided by this medical officer, which was not always the case with others, but he remained unknown to the staff of our unit. His anonymity was revealed to me, however, on joining the Regional Hospital Board in Edinburgh in 1957 when one of the first letters to come across my desk was from the Western General Hospital and signed:



It should be noted that John Forfar's handwriting has not improved with the passing of the years.

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College Affairs

EXTRACT FROM THE PRESIDENT'S ADDRESS TO THE ANNUAL GENERAL MEETING 1 DECEMBER 1994

This is a time, certainly in the United Kingdom, of remarkable changes in the affairs of medicine, both in the nature of medical practice itself and in the operational background in which it takes place. This environment of change, whilst invigorating, challenging and, of course, intended to bring benefit to patients, may lead to periods of profound uncertainty and even instability, and hence in some cases to a reduction in the quality of general care and in the standards of medical practice. Much of this may arise from a weariness and sagging of morale in the foot soldiers: a varied group of people who provide health care and come face to face with patients. In recent times they have become exhausted by the extra efforts demanded of them by a seemingly uncontrollable process of change, both frenetic and unremitting, which is fuelled by groups of fresh managerial colleagues with new resources. The foot-soldiers have also become less involved in the process of governance of health care and, as a consequence, may suffer from a feeling of loss of their former responsibilities.

There is, I believe, sufficient evidence to conclude that we are well into a period of uncertainty, similar to that which in 1858 confronted the Fellows of this College by the challenges of the new Medical Act, and in 1946, when our Fellows bore a substantial burden of responsibility during the Government's consultations that preceded the passing of the National Health Services Act. Thus, as we look around us in 1994 we should take heart from those Fellows who have gone before, for they stood firm and, although prepared to accept much and often uncomfortable change, resolutely sustained their commitment to high standards of practice and in the end (sometimes a long time in coming) they succeeded. For their dedication the profession has received grateful thanks and respect from countless patients and the general public over the subsequent decades.

As incoming President, I am moved to reflect that this College, along with its sister Colleges and sooner rather than later, may need to address more directly the current challenges in some of the affairs in medicine. For it is our unique responsibility to safeguard and maintain the integrity and ethic of the profession, the quality of its clinical practice and its empathy with the general public. These have always been matters of importance in their own right, but now are of increasing concern to patients and their relatives. Let there be no doubt that the tasks ahead are likely to be substantial and that the opportunities for both success and failure are perhaps unlimited. But let there also be no doubt that the size and nature of these tasks will require contributions from Fellows and Members who have not served on Council or College Committees and who may not have expected to be called upon to do so. They will bear witness then to the College's corporate commitment to high standards of practice, to the common weal, to its independence and its concern for the welfare of the profession insofar as this affects its responsibilities to discharge its duty to patients and the community.