Does this fatigue originate centrally in the brain or peripherally in muscle? The findings on nuclear magnetic resonance of an early and prolonged fall in muscle pH with exercise suggested peripheral lesions,¹⁶ but later reports have been less convincing, with a schizophrenic patient showing the same changes.¹⁷ As these studies have not controlled for muscle disuse through inactivity this finding might be an effect rather than a cause. Stokes and colleagues used a twitch interpolation technique and showed that fatigue could not be explained by peripheral mechanisms—so was likely to be central in origin.¹⁸

With what other symptoms is fatigue associated? Chen examined a large community sample and found that one in five subjects reported fatigue for over one month.¹⁹ Fatigue was strongly associated with self reported anxiety, depression, and “stress.” General practice studies have reported similar findings. Kroenke and colleagues screened an unselected group of 1159 consecutive patients, a quarter of whom reported fatigue as a serious problem for more than a month.²⁰ Patients were excluded if they were currently under the care of a psychiatrist or had an obvious medical disorder, yet four fifths of the fatigued patients reported depression or somatic anxiety, or both, compared with one in eight of the controls.

What proportion of patients have psychiatric or “organic” diagnoses? Morrison studied 176 patients with unexplained fatigue of recent origin and found that two fifths were later given a psychiatric diagnosis (mainly depression and anxiety).²¹ “Organic” diagnoses were made in a further two fifths of patients, with viral illnesses being the commonest, especially in the young. Of the remaining 35 patients, 21 had mixed diagnoses and the rest were undetermined. Psychiatric diagnoses were particularly associated with a duration of symptoms longer than four months.

Studies of patients with fatigue of longer duration showed that two thirds of patients had a recognisable psychiatric disorder. Taerk and colleagues studied 24 patients with postinfectious “neuromyasthenia,” 16 of whom scored more than 9 on the Beck depressive inventory.²² Manu and colleagues studied 100 self referred patients with chronic fatigue of 13 years’ mean duration: 66 subjects had current DSM III psychiatric disorders.²³ Wessely and Powell studied 47 patients with unexplained fatigue referred to the National Hospital for Nervous Diseases.²⁴ They found that 34 had psychiatric disorders even after exclusion of fatigue as a symptom. This compared with 12 of 33 controls with peripheral neuromuscular disorders. The commonest diagnosis in these last two studies was major depressive disorder in half the patients, with a further 15% having a somatisation disorder. It is difficult to assess whether these psychiatric disorders are primary or secondary to the fatigue.

Three points should be noted in relation to these studies: a third of patients with fatigue had no evidence of psychiatric disorder; generalisation from selected populations may be unwise; and “organic” and “psychiatric” diagnoses may be found together in the same patients,^{21 25} making a simple “either/or” classification inappropriate.^{10 25} The present evidence suggests that a chronic fatigue syndrome does exist, certainly after particular infections. The symptoms resemble the more narrowly defined concept of neurasthenia. The reliability of the concept over time is uncertain. If symptoms persist treatable psychiatric disorders will be found in two thirds of patients.

We should, however, remember what Robert Whytt wrote in 1765: that physicians diagnosed as “nervous, hypochondriac, or hysteric . . . all those disorders whose nature and causes they were ignorant of.”²⁶ Given our present inability to cure patients with chronic fatigue syndrome we should

therefore treat what we know is treatable while keeping an open mind about aetiology.²⁷

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Conventional and complementary treatment for cancer

Time to join forces

Diagnosing cancer provokes stress in patients and their families. Treatment given in unfamiliar surroundings is often frightening and unpleasant, especially as the results are uncertain. Although great advances have been made in managing some tumours, for most there is little that is new.¹ Better treatments will certainly be devised, but how can we help our patients now?

The psychological stresses associated with cancer have been well described,^{2 3} but all too often they are concealed by the patient and so may go unrecognised. Yet perhaps one in two patients with cancer is psychologically disturbed, and the problem is often treatable or preventable.⁴ Patients’ widespread need for further information and guidance about cancer is shown by the growing use made of the telephone advice service offered by the British Association of Cancer United Patients (BACUP).⁵

After leaving hospital many patients turn to one of the many voluntary self help groups or cancer support centres. Most of these groups offer simple social support, counselling, and some forms of complementary medicine. These may include sessions of relaxation and meditation, either in a group or individually with a healer, and an introduction to the Simonton technique of visualising images designed to promote healing and recovery.^{6,7} Simple nutritional advice recommending vegetarian food is usually also given. Few groups have an attending doctor, and all work outside the conventional routes of medical referral.

These centres and support groups seldom have any defined link with the National Health Service, and all are self financing.⁸ They do not see themselves as offering cures for cancer but aim at supporting anxious people at a time of crisis, disclosing and strengthening their inner resources, and pointing the way to self help—complementing rather than conflicting with conventional cancer treatment. Their patients are grateful for help given in a sympathetic and unhurried atmosphere, which is rarely achieved in a hospital setting. Some report that the insight they gain has favourably transformed their view of themselves and their role in life, irrespective of the outcome of the cancer treatment.

Realisation of the need for psychological support has led to some oncology clinics including a cancer counsellor or psychotherapist, a professional who has had special training in the psychological problems and communication difficulties that arise with cancer.⁹⁻¹³ We suggest a natural extension of this: oncology clinics should set up their own cancer support group, run as a day centre in or near the hospital for those who need it, with counsellors and other staff working both in the hospital and in the group. Contacts made initially with patients in the wards or clinics could be continued as necessary afterwards. Additional services offered could be those of a social worker, chaplain, art therapist, and visiting doctors, as well as those provided by voluntary assistants.

The style of accommodation for such a support centre is important. It should avoid a hospital atmosphere and be informal, comfortable, and welcoming. At least one room should be big enough for group meetings, with other smaller rooms for individual consultations. There should be a kitchen, toilet facilities, and easy access for unwell or disabled patients.

Of course there are some extremists in complementary medicine who claim miracle cures based on anecdote and not on rigorous clinical trial. Such people are as damaging as those doctors who think that their relationship with a patient is threatened by sharing it with a colleague outside conventional medicine. But if the patient benefits—why not?

Such an organisation would cost money, but this would be only a small proportion of the total cost of cancer treatment. Overcoming the present hiatus between hospital and voluntary support services, it would recognise and integrate the role of support groups, permitting a much needed appraisal of their complementary methods. If the culture of the new National Health Service really will be more flexible then support services for cancer patients and others stand a good chance of success.

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A unique opportunity to upgrade genitourinary medicine

Doctors must join ministers in pushing for better services

In a recent parliamentary debate on AIDS the Health Minister, Mr David Mellor, identified genitourinary medicine as a cinderella service, thus recognising what many have long known.¹ The health service for venereal diseases was created in 1916 because of a major public health problem,² but since then development of the specialty has been inadequate. As recently as the late 1970s half of the 189 genitourinary medicine clinics in England and Wales were open for 10 hours or less each week, some health districts (as now) had no service at all, while some doctors in the clinics were using inappropriate approaches to diagnosis and treatment.³ This audit was one of the elements that helped the specialty to put its house in order. In addition, the specialist advisory committee in genitourinary medicine of the Joint Committee on Higher Medical Training has dragged the specialty towards the twentieth century by making it accept entry criteria and training programmes equivalent to those for all the other medical specialties.

Despite these internal efforts much has happened externally to put impossible pressures on those working in clinics. Over the decade 1976-86 the number of new cases seen in all genitourinary clinics in the United Kingdom has risen by two thirds from 418 623 to 702 223, increases in all regions in England varying from 20% to 120%. Staff have, however, increased over the same period by only 15%.⁴ A survey by the committee on genitourinary medicine of the Royal College of Physicians has shown that an 80% shortfall in consultant posts has occurred in England and Wales and that posts would need to be increased from 128 to 233 over 10 years to rectify this, which would require creating 12 additional senior registrar posts.⁵ The Joint Planning Advisory Committee, which is responsible for supervising medical manpower, has not accepted this increase as it will use only the plans for consultant expansion given to it by the regions and the Department of Health. Unfortunately, most regions have not thought about the issue of manpower in genitourinary medicine and have minimal plans or no plans for expansion. Thus at the time of the committee's review of genitourinary medicine in 1988 the regions in England and Wales had plans