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Epidemic Malaise

SIR.—I have read with interest but incredulity the papers by Drs. C. P. McEvedy and A. W. Beard (3 January, p. 7).

I am a general practitioner in North London, and the epidemic of benign myalgic encephalomyelitis which occurred there between the autumn of 1964 and the summer of 1966 was mainly in my practice. I saw about 370 patients of whom at least 20 were seriously ill and a high proportion of whom have not been restored to their previous good health. It is interesting to note that the varied reasons given on request for a visit included "heart attack," "gall bladder trouble," "dizziness with vomiting," "abdominal pain," "tonsillitis," and "lumbago." Hyper-ventilation was never observed, but there were cases in which hypoglycaemia, abnormal glucose tolerance curves, ankle clonus, extensor plantar responses, and nystagmus were found. All had the characteristic "ghastly pallor."

Cases occurred sporadically and in the majority of instances the patients did not know each other. The social background varied from van driver to dentist and office cleaner to doctor's wife. The sex incidence conformed to what could be expected in a woman doctor's practice. The age range was from four years old to late middle age. An observation made by nearly all patients was "I have never felt like this before."

A careful and detailed history was taken in all cases; this was based on a questionnaire prepared by myself and amended from time to time in the light of further experience. A diagnosis of benign myalgic encephalomyelitis was not considered to have been established unless most of the following were present: low-grade pyrexia, headache, blurred vision and/or diplopia, occipital pain, stiff neck, vertigo with positive Romberg test, nausea and/or vomiting, lymphadenitis, pharyngitis, lower costal pain, generalized weakness and depression, emotional lability in previously stable personality, loss of memory, profound fatigue unrelieved by

rest, insomnia and/or vivid dreams often in colour, impaired perception to sound, frequency or retention of urine, diarrhoea or constipation, areas of muscle tenderness, and neuritis with or without paresis.

Psychiatric disturbance was not observed if an early diagnosis was combined with bed rest. Hypothermia as low as 95°F. (35°C.) was recorded in convalescent patients who complained of fatigue and feeling cold. Prolonged and often permanent incapacity has been a feature of these cases, and it is a vital part of after-care that patients should recognize the limitations which the disease has imposed upon them. They are advised to live within these limitations as excessive physical or mental stress can precipitate a recurrence of symptoms.

Drs. McEvedy and Beard did not say whether they have seen a case of benign myalgic encephalomyelitis, and I personally refute their suggestion that a diagnosis is more likely to be made by a practitioner familiar with the disease. I diagnosed the first case in the North London epidemic without having previously seen it. It is my hope that the views expressed by Drs. McEvedy and Beard will not be taken seriously, especially as the implied diagnosis of "hysteria" to a seriously ill patient can cause acute distress and prolong the illness indefinitely. Inability to concentrate, fumbling and lack of co-ordination in finer movements, as well as disturbances in the autonomic nervous system are constant features in the aftermath, and if a diagnosis of "hysteria" is even hinted, the patient experiences a profound loss of confidence in his medical advisers. Restoration of confidence may take months. It is essential to treat this disease seriously, and to give strong reassurance and encouragement in the difficult period when the patient is learning to "come to terms" with his disability.—I am, etc.,

BETTY D. SCOTT.

London N.3.

SIR.—Dr. C. P. McEvedy and Dr. A. W. Beard (3 January, p. 7) have done a real service in making the profession more aware of the psychological origins of some outbreaks of illness previously assumed to be infective or toxic in origin. Perusal of the lay press for any period will give evidence of many illnesses in individuals and groups of like origin, though usually in less dramatic form than those they described.

Psychological origins for illness must very obviously be borne in mind when considering a multitude of incidents ascribed to food poisoning, gassing by boiler fumes, explosive outbreaks of diarrhoea, over-exposure to swimming baths chlorine, winter vomiting disease, and hitch-hiker's paralysis, etc., but one must also be aware of the great practical difficulties in investigating such incidents. "Hysteria" would seem to be essentially a diagnosis of exclusion, but this cannot be arrived at without environmental or personal examinations which would strengthen the belief for a physical cause. Again, where a number of persons is concerned, the majority might not be physically ill but some individuals might well be, and how are we to detect these without aggravating the outbreak? It must in any event be extremely difficult for a doctor to state publicly his views about the psychological origin of an outbreak even if he believes it to be true.

I can only suggest that, so far as medical officers of health are concerned, we should firstly bear the possibility constantly in mind, secondly do what we can to reduce the emotional tension by "playing it down," and thirdly refer to their own general practitioners those affected members of the group who after dispersal have a continued need in their own or their parents' eyes for medical attention, thus dissipating the aggravating effects of investigation and yet making provision for the genuinely physically ill. Needless to say the general practitioners should be fully informed. Of course, I do not offer this as more than the most