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Editorial note

Unusually for *Psychological Medicine*, we publish below six letters concerning the paper by White *et al.* (2013) on the PACE Trial. The UK Office of the Journal received 15 letters criticizing aspects of this paper, but it seemed unlikely that all of these letters originated entirely independently since a number arrived on successive days and reiterated the same points. Nevertheless, in the spirit of scientific openness we have published six of the letters which cover the main criticisms, and invited Professor White to reply to them.

References

White PD, Goldsmith K, Johnson AL, Chalder T, Sharpe M; PACE Trial Management Group (2013). Recovery from chronic fatigue syndrome after treatments given in the PACE trial. *Psychological Medicine*. Published online: 31 January 2013. doi:10.1017/S0033291713000020.

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Letter to the Editor

Comments on ‘Recovery from chronic fatigue syndrome after treatments given in the PACE trial’

In their paper on recovery rates in the PACE trial, White *et al.* (2013) acknowledge that ‘objective measures of physical activity have been found previously to correlate poorly with self-reported outcomes’. Yet, there is no attempt to utilize the Six Minute Walking Test results. The best results were a mean of 379 metres walked in the graded exercise therapy condition, a gain of 67 metres in 52 weeks, 35 metres more than the specialist medical care (SMC)-only group (White *et al.* 2011). The cognitive behaviour therapy group showed no improvement compared with the SMC group. The distance of 379 metres is exceeded by patients listed for lung transplantation (Kadikar *et al.* 1997) and by older patients with chronic heart failure (Lipkin *et al.* 1986). Given the recognized

problem with self-reported outcomes, reliance solely on such measures leaves open the question of the validity of the recovery criteria of PACE.

Declaration of Interest

None.

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Letter to the Editor

‘Recovery from chronic fatigue syndrome after treatments given in the PACE trial’: recovery or remission?

White and colleagues conclude from the results of the PACE trial that ‘recovery from CFS (chronic fatigue syndrome) is possible, and that CBT (cognitive behavioural therapy) and GET (graded exercise therapy) are the therapies most likely to lead to recovery’ (White *et al.* 2013).

However, in the body of the text, they qualify their use of the term 'recovery'. Citing Nisenbaum *et al.* (2003) they write, 'recovery may be taken to imply that the patient has made a transition from ill health to remission and also is at little risk of recurrence' but then acknowledge that, in the absence of longitudinal data, it is not possible to discriminate between remission and recovery in CFS.

Thus, in the current paper, 'recovery' does not mean recovery as understood by Nisenbaum but 'recovery from the current episode of the illness', a state described by Nisenbaum as 'remission'.

This difference is important because CFS is known to pursue 'a fluctuating course with periods of relative remission and relapse' (CFS/ME Working Group, 2002) and Cochrane reviews of CBT (Price *et al.* 2008) and GET (Edmonds *et al.* 2004) have reported inconsistent findings at long-term follow-up, with some studies showing that initial gains can diminish with time. Writing about the PACE trial, Edmonds *et al.* concluded 'Even when the results of that study are available, it is possible that uncertainty will remain. Further randomized studies are needed, with longer follow-up, to determine whether patients who respond to exercise stay well or relapse.'

Declaration of Interest

None.

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Letter to the Editor

'Recovery from chronic fatigue syndrome after treatments given in the PACE trial': an appropriate threshold for a recovery?

The main trial recovery criteria, described by White *et al.* (2013), allow participants with SF-36 physical function scores of ≥ 60 to be classed as recovered if, for example, their 'main symptom' is no longer fatigue.

In terms of clinical interpretation, such a threshold is problematic because it is in conflict with how the condition itself is defined. For example, it indicates worse impairment than the PACE Trial entry criteria threshold of ≤ 65 (White *et al.* 2011) and the diagnostic threshold of ≤ 70 used by Reeves *et al.* (2005) to indicate 'substantial' physical impairment.

Further, a score of ≤ 65 has been used to indicate severely impaired physical function in similar patient groups (Stulemeijer *et al.* 2004; van't Leven *et al.* 2009).

Declaration of Interest

None.

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