Chronic fatigue syndrome

Sir: Wessely's review (1997) of books and reports on chronic fatigue syndrome (CFS) fails to mention the ground-breaking report of the independent National Task Force on CFS/PVFS/ME (Tyrrell, 1994). Before producing its report, the Task Force (supported by the Department of Health) consulted widely, held a consensus meeting, and carefully considered the views of the patient organisations. Perhaps for these reasons, its report has escaped the severe criticism, mentioned by Wessely, that met the report of the Royal Medical Colleges (Anonymous, 1996).

Wessely presents a picture of worthy psychiatrists motivated by the "desire for decision-making on the basis of evidence" compared with patients who, driven by emotion, often have "equal and opposite demands". Patients may find this provocative and simplistic, particularly those who, despite the reports of the Task Force and of the Royal Medical Colleges, still find that they are not believed or listened to.

Anonymous (1996) *Chronic Fatigue Syndrome: Report of a Committee of the Royal Colleges of Physicians, Psychiatrists and General Practitioners*. London: Royal College of Physicians.

Tyrrell, D. (chairman) (1994) *Report from the National Task Force on Chronic Fatigue Syndrome (CFS), Post Viral Fatigue Syndrome (PVSF), Myalgic Encephalomyelitis (ME)*. Bristol: Westcare.

Wessely, S (1997) Reading about: chronic fatigue syndrome. *British Journal of Psychiatry*, **171**, 92–93.

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Psychological consequences of road traffic accidents in children and adolescents

Sir: I read with interest the paper by Di Gallo *et al* (1997) about the early psychological consequences of road traffic accidents (RTAs) in children and adolescents, but think their methodology was seriously flawed. The authors included a high proportion of brain-injured subjects (as defined by "lost consciousness") in their cohort of RTA victims. I do not think that the psychological outcome of brain injury can be assumed to be the same as the psychological consequences of "bruises, grazes or lacerations". The confounding effect of so many brain-injured subjects brings into question the conclusions drawn by the authors. In fact, the rate of post-traumatic stress disorder might have been higher if brain-injured subjects had been excluded from the study. I do not think that RTA victims are a homogeneous group and any future research should bear this in mind.

Di Gallo, A., Barton, J. & Parry-Jones, W. Ll. (1997) Road traffic accidents: early psychological consequences in children and adolescents. *British Journal of Psychiatry*, **170**, 358–362.

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Author's reply: I agree with Dr Fearnley that young RTA victims are not a homogeneous group and that the inclusion of subjects with head injury may have influenced the study results. RTAs are frequently associated with head injury, and any consideration of the psychological consequences represents a complex clinical and diagnostic task. Even in the absence of physical signs, or with uncertain ones, head injury can cause a wide range of post-traumatic disturbances. Possible symptoms include anxiety, irritability, sleep disturbances, numbness, memory problems, headaches and dizziness (Alves *et al*, 1986), all potentially overlapping with symptoms of depression or post-traumatic stress disorder. Often the distinction between definite organic and psychological causation cannot be determined with certainty and, in clinical practice, both need consideration.

Head injury, however, is only one possible confounding factor that has to be considered in analysis and discussion of a study involving RTA victims. There are many others, such as type and circumstances of the accident, or age and developmental stage of the victim. Our study was designed as an exploratory investigation, aimed at describing the early psychological reactions of an unselected sample of child and adolescent RTA victims. In our cohort, psychological symptoms of subjects with head injury did not differ from those without head injury three months following the accident. This result has to be considered in relation to the limitations of methodology and size of our sample. General conclusions can surely not be drawn. I hope that future research will provide more evidence in this neglected field.

Alves, W. M., Colohan, A. R. T., O'Leary, T. J., *et al* (1986) Understanding post-traumatic symptoms after minor head injury. *Journal of Head Trauma Rehabilitation*, **1**, 1–12.

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Sleep disturbance and Huntingdon's disease

Sir: It is well recognised that sleep disturbance is a common accompaniment of Alzheimer-type dementia. However, the association between the rare genetic neurodegenerative condition Huntingdon's disease (HD) and sleep problems has received only scant attention. We decided, therefore, to conduct a postal self- or carer-completion questionnaire community survey through the British HD Association.

The response rate was 56.4% (292 out of 518) and the reported prevalence of sleep problems in HD sufferers was 87.8%. Sleep problems were rated by 61.7% as either 'very' or 'moderately' important contributing factors to overall problems. Specifically, the sleep problems reported were, in rank order: restless limb movements, periodic jerky movements, waking during the night, sleepy by day, and early wakening. Perseverance of daytime choreoathetoid movement by night was reported by 50.4%. Over half (52.7%) had sought help for their sleep problems, however the sole treatment received (sedative medication) was perceived as being largely unhelpful.

The majority of the principal carers (commonly spouses) also reported significant sleep disruption, primarily attributable to the sufferers' sleep problems, which adversely affected their relationship with the sufferer.

Thus, we conclude that most HD sufferers experience significant sleep problems, which appear to result from one or a combination of the following factors: persistence of abnormal bodily movements, psychiatric comorbidity, poor sleep habits, and sleep fragmentation resulting from neurodegeneration. Given the high rates of sleep disorders and their contribution to the overall burden of illness, it would seem prudent to explore therapeutic strategies within this very needy group.

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Risperidone-induced leucopenia and neutropenia

Sir: The atypical antipsychotic risperidone is claimed to be haematologically safe (Curtis & Kerwin, 1995). However, risperidone

was suspected of causing reversible neutropenia during a cold (Meylan *et al*, 1995). The same patient did not develop neutropenia at re-challenge two years later (Bondolfi *et al*, 1996). In another case, agranulocytosis was reported after risperidone was combined with clozapine (Godleski & Sernyak, 1996). We report a case of risperidone-induced leucopenia and neutropenia in a patient who had previously developed blood dyscrasia on clozapine.

A 63-year-old White male patient with a 45-year history of chronic paranoid schizophrenia was unsuccessfully treated with almost every antipsychotic that came on the market. Clozapine treatment was stopped because of leucopenia (white blood count (WBC) 2.5×10^9/l, neutrophil count 1.2×10^9/l). During the next 10 months the patient did not receive antipsychotics and the psychotic symptoms gradually worsened. One week after risperidone 2 mg b.i.d was added to 100 mg methotrimeprazine the WBC fell from 4.5 to 3.2×10^9/l and the neutrophil count from 3.7 to 2.3×10^9/l. During the next six months the WBC and neutrophil counts were slowly but steadily diminishing and both drugs were stopped at a WBC of 2.7×10^9/l and neutrophil count of 1.4×10^9/l. Two days later WBC rose to 3.2×10^9/l and neutrophil count to 1.9×10^9/l, and six days later these values were 4.1 and 2.4×10^9/l, respectively. Bone marrow puncture, done one week after stopping risperidone, had excluded other haematological disease.

Four weeks later the patient was re-challenged with risperidone 2 mg b.i.d. at a WBC of 3.7×10^9/l and neutrophil count of 1.9×10^9/l. He was also receiving lorazepam 1 mg t.i.d. and biperiden 2 mg t.i.d. After seven weeks the WBC and neutrophil counts fell to 2.9 and 1.4×10^9/l, respectively, and risperidone was discontinued. During the next six weeks these values slowly rose to 3.9 and 2.1×10^9/l, respectively. There were no signs of infection and erythrocyte and platelet counts were normal, both at initial treatment and at re-challenge.

Mahmood *et al* (1996) recommend risperidone in patients who developed neutropenia or thrombocytopenia during treatment with classical antipsychotics. There are no published reports on risperidone treatment in patients who have developed leucopenia on clozapine. Our report indicates that some of these patients may require haematological monitoring during risperidone treatment.

Bondolfi, G., Morena, P., Dascal, D. R., *et al* (1996) Risperidone and reversible neutropenia: a negative rechallenge. *European Neuropsychopharmacology*, **6**, 257.

Curtis, V. A. & Kerwin, R. W. (1995) A risk–benefit assessment of risperidone in schizophrenia. *Drug Safety*, **12**, 139–145.

Godleski, L. S. & Sernyak, M. J. (1996) Agranulocytosis after addition of risperidone to clozapine treatment. *American Journal of Psychiatry*, **153**, 735–736.

Mahmood, T., Silverstone, T. & Spittle, B. (1996) Risperidone appears safe in patients with antipsychotic-induced blood dyscrasias. *International Clinical Psychopharmacology*, **11**, 53–54.

Meylan, C., Bondolfi, G., Aubert, A. C., *et al* (1995) Reversible neutropenia during a cold: possible involvement of risperidone? A case report. *European Neuropsychopharmacology*, **5**, 1–3.

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Anxiety and depression in asylum-seekers

Sir: In response to the paper by Silove *et al* (1997) we would like to make a few additional remarks from our experiences with traumatised refugees and asylum-seekers. At 'de Vonk' we treat patients with trauma-related symptoms.

Silove *et al* conclude that procedures for dealing with asylum-seekers may contribute to high levels of stress and psychiatric morbidity, as measured with instruments like the Hopkins Symptom Checklist (HSCL) and the Harvard Trauma Questionnaire (HTQ). They suggest that current procedures are re-traumatising. Although we probably have the most severe cases, our data (n=172) do not support this: when subjects are referred for treatment, no significant differences are found between refugees and asylum-seekers on the HSCL or HTQ (Rodenburg, 1996). Social circumstances may have their impact on symptomatology in asylum-seekers, but the same may apply to refugees, although these circumstances may be different. It is easy to understand that in refugees, who do not have to live in uncertainty any more, reflections on the past in difficult social circumstances may lead to heightened levels of anxiety, depression, and post-traumatic stress disorder. This view is supported by the fact that subjects with a temporary status have the lowest scores on anxiety and depression. This lower score may reflect 'hope', contrary to asylum-seekers living in uncertainty and to refugees with no prospects.

Rodenburg, J. J. (1996) *Trauma Gerelateerde Klachten bij Vluchtelingen en Asielzoekers: Eeen Inventarisatie Binnen Centrum '45 De Vonk (Trauma-Related Symptoms in Refugees and Asylum-Seekers: A Survey in Centrum'45 De Vonk)*. Leiden: University of Leiden, Department of Psychology.

Silove, D., Sinnerbrink, I., Field, A., *et al* (1997) Anxiety, depression and PTSD in asylum-seekers: associations with pre-migration trauma and post-migration stressors. *British Journal of Psychiatry*, **170**, 351–357.

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One hundred years ago

The Moscow meeting

The Moscow meeting appears to have been satisfactory both in the numbers attending and in the number of papers read. The section "des maladies nerveuses et mentales" received a very strong contingent of our own speciality.

A wave of heat, however, appears to have made attendance in crowded rooms, with the thermometer over 80 degrees, almost unbearable, with the result that the discussions were abbreviated, and the interesting excursions provided were fully attended and appreciated.

REFERENCE

Journal of Mental Science, October 1897, 842.

Researched by Henry Rollin, Emeritus Consultant Psychiatrist, Horton Hospital, Epsom, Surrey

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