Reminiscences of the chronic fatigue syndrome

Peter Snow has been a rural general practitioner in Tapanui for many years. He was the first New Zealand medical practitioner to describe an outbreak of an illness characterised by chronic fatigue in West Otago in 1984.

Hard to believe that it is now 18 years since Marion Poore, Charlotte Paul and I researched an apparent outbreak of a chronic fatiguing illness in West Otago, New Zealand, the results of which we published in the *New Zealand Medical Journal* in 1984.[1] I recall the concern I felt at the time when the media took such an intense interest. In those days we were just emerging from the era when the profession did not communicate with the media in any of its forms and to do so was considered to be somewhat unethical and certainly cast doubt on the validity of the researcher's work amongst one's colleagues.

Much to my chagrin, there appeared to be increasing concern created by our article, about the fatigue phenomenon, both nationally and internationally, by the media and public in general. I can recall poems, cartoons (*NZ Herald*) and songs – *I have got those old Tapanui flu blues.* I was somewhat paranoid at the time about the press making light, dumbing down if you wish, of the subject, which I considered an important cause of distress in our community. On reflection, however, the media's interest truly reflected the recognition of the problem by the public and did reveal to those of us interested the extent of the problem both locally and globally. It was of immense relief when Campbell Murdoch appeared on the scene to take up his position as the first Elaine Gurr Professor of General Practice in New Zealand. Campbell quickly established the need for research into the phenomenon and of course was much better equipped to handle the media than I. Nevertheless, despite the disapproval of many of our colleagues of the day, what the press and Campbell did do was to reveal the widespread nature of the illness. It also uncovered the resistance at the time by the profession to the condition, and to the widespread dissatisfaction by the affected public to the lack of understanding of the debilitating condition.

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Since that period, much research has been done and published. However none have been able to implicate a single all encompassing aetiology. Poore, Paul and Snow revisited the outbreak and more clearly defined the syndrome in 1985.[2] My interpretation of the findings indicated the relationship of fatigue to bowel disorders, which included diaorrhoea, constipation, frequent mushy bowel motions, rotten egg flatus, post prandial bloating, abdominal distention, food intolerances particularly to milk products, alcohol, fatty foods, spicy foods, along with the multiplicity of signs such as headache, lymphadenopathy and others. Blood tests were invariably normal, as were faecal analyses. About this time, Tim Bailey Gibson, a GP from Masterton, New Zealand, in response to the publicity had suggested from research he had done that giardiasis was an aetiology worth considering.

Because of the bowel disorder link we embarked on a programme using metronidazole, which we found helped temporarily in some instances and in others made sufferers worse. We called a halt to these trials. Subsequent to this, the work of Martin Wolfe of the George Washington University, published as a review in 1992,[3] rekindled our interest in the possibility of giardiasis being a factor. Martin indicated the acute and chronic nature of the disease and the problem of poor laboratory yield of cysts in the chronic form. He cited about 1% yield in routine faecal testing rising to 10% with more aggressive searching. This makes laboratory evidence of the disease difficult. He asserted that if the syndrome fits to the chronic giardia syndrome, then treat without the evidence; if patients get better, then giardia was probably the diagnosis.

The work of Tim Browne (of Massey University), with CDC, MAF and DOC revealed the widespread infestation of our waterways with Giardia Lamblia and also the universal infestation of domestic and feral birds, mammals and reptiles. We considered it possible that an infecting agent was significant in our cases and

therefore embarked on a therapeutic programme.

Our approach was to use the then newer nitroimidazole, tinidazole, which was said to have a 96% cysticidal rate compared to metronidazole 46%; both have a very high trophozoite kill rate. The main difference between acute and chronic giardiasis is the encystation of the protozoan onto the villi of the small bowel in the chronic form. This explains the effectiveness of metronidazole in the acute illness. It is ineffective in the chronic illness. Tinidazole was administered in a low dose of 500mg for a long period of 30 days at least. All recipients were made aware of the side effects such as a metallic taste in the mouth, nausea and vomiting. They were also made aware of the need for prolonged treatment and of the slow recovery period.

A 10 year follow-up of the original group studied was conducted by Paul Levine of the Department of Medicine, George Washington University Medical Centre, and myself. This study revealed that recovery of all the sufferers was complete and these findings were published in 1997.[4]

A further study was also undertaken by Dr Mike Holmes of the Microbiology Department of the University of Otago and myself, and another study of 300 patients by the same researchers, both unpublished, revealed the multifactorial nature of chronic fatigue. These studies indicated, of every hundred cases of fatigue that come to the general practitioner, something like 15 will have a diagnosable disorder, and 15, eventually, if followed up long enough, will develop a diagnosable disorder. In our series, 65 showed that their fatigue was associated with a bowel disorder and responded to nitroimidazole therapy, the remaining five would have no diagnosis and probably is the group that would fulfil the criteria of the Centre of Disease Control USA for the chronic fatigue syndrome.

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You may accept or reject these figures, but what I am trying to say is that, in my experience, the majority of people who cross the physician's door with chronic fatigue as the presenting symptom will be unlikely to have the chronic fatigue syndrome as defined by the CDC; indeed it is probably less than 5% of the total. I believe in this small group of people that even their plight will eventually reveal the multifactorial nature of their condition.

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What I find disturbing now is the exact opposite to the problem we started in 1985. Then it was getting physicians to accept that there was a chronic fatiguing condition, whereas today I fear that the diagnosis is being applied before adequate investigation has taken place often leaving the patient's real disorder undiagnosed and untreated. Unfortunately chronic fatigue syndrome has become a convenient dumping ground for the difficult to diagnose. Fatigue is a presenting symptom of many disorders. In our series the bowel link was strong. I might add any patients that I have had to deal with from other areas demonstrate a similar bowel link. If there is an unexplained bowel disorder associated with fatigue, giardiasis is a condition that should also be excluded, remembering that fatigue, chronic or otherwise, is a factor in any of the numerous conditions that afflict our patients.

General practitioners are in a good position to assist sufferers with chronic fatigue because of their knowledge of their patients and their ability for follow-up care. Nevertheless I have always maintained that chronic fatigue is an old disorder that has become more prominent today because of the loss of the General Consulting Physician Specialist. Those of us who have had the privilege of working in that era with these skilled generalists will understand the immense benefit that they gave to our difficult to diagnose patient. Alas, they have disappeared and probably general practitioners, unless they have an intense interest in chronic disease and the consulting time available, are a less effective substitute for the specialist General Physician.

References

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