

Malcolm Hooper and Margaret Williams ask Peter White some questions

31st July 2004

In the [British Journal of Psychiatry 2004:185:95-96 \(IN DEBATE: There is only one functional somatic syndrome\)](#), psychiatrists [Simon Wessely and Peter White](#) revisit the notion proposed five years ago by Simon Wessely and Mike Sharpe in The Lancet. That notion was that what they decreed to be medically unexplained symptoms and syndromes such as irritable bowel syndrome, fibromyalgia and chronic fatigue syndrome should be combined into a single psychiatric disorder that they termed “Functional Somatic Syndrome” (Lancet 1999:354:936-939).

Wessely states that he and Sharpe stand by their thesis and that they “do not expect that improved understanding will come from further statistical manipulations of symptoms”.

Peter White, however, argues against the motion, stating: “The concept of a general functional somatic syndrome does not lead to better understanding of aetiology. For instance, there is a five-fold risk of chronic fatigue syndrome in patients suffering from infectious mononucleosis, whereas there is no evidence that fibromyalgia is caused by infectious. Lumping (them) together would have reduced the chance of finding this effect (because of dilution). It is only by separating...that we will advance understanding of causation. I conclude that the concept of a general functional somatic syndrome is unhelpful in understanding illness, aetiology, treatment and outcome”.

This is notable, because it is the same Peter White who is heading the MRC PACE trials on “CFS/ME” that from the outset are specifically designed to lump together CFS and fibromyalgia.

What can be White’s rational explanation for holding such divergent views about the same issue?

Given that White is now on record as believing it is only by **separating** illnesses with unexplained physical symptoms that we will advance the understanding of treatment approaches, on what evidence does he intend to lump CFS and FM together in an MRC study whose objective is widely believed to be to prove that cognitive behavioural therapy will be confirmed as the best management option for everyone suffering from supposedly unexplained “fatigue”?

Why is it that some psychiatrists endlessly proclaim the need for “evidence-based” medicine, yet persist in ignoring the evidence when it does not accord with their own strongly-held beliefs, for example, the evidence that there are significant molecular alterations specific to the gut in patients with irritable bowel syndrome (IBS) that support the assertion that disordered gastrointestinal function in IBS involves changes intrinsic to the bowel? (see Coates et al. Molecular defects in mucosal serotonin content and decreased serotonin reuptake transporter in ulcerative colitis and irritable bowel syndrome. *Gastroenterology*: 2004:126:1897-1899).

As for ME/CFS, these same psychiatrists might (or perhaps might not) wish to consider the published findings of Gwen Kennedy and colleagues from the Vascular Diseases Research Unit at Dundee that there is proof (not supposition) that patients with ME/CFS have an underlying detectable immunological abnormality that is consistent with an activated inflammatory process such as a persistent or reactivating infection or a toxic state. (see Increased neutrophil apoptosis in chronic fatigue syndrome. Kennedy G, Spence V, Underwood C, Belch JJ; J Clin Pathol 2004;57(8):891-893).

Such findings add to the existing mountain of established knowledge about ME/CFS and provide yet more biomedical evidence that the physical symptoms exhibited in ME/CFS are no longer “unexplained” any more than in IBS, even if causation remains unexplained (and will continue to remain so as long as “policy” dictates that causation must not be looked for).

Although the underlying disrupted biology is different in ME/CFS from that found in organophosphate (OP) induced illness, the resolute refusal by Government bodies such as the Department of Health and the Medical Research Council to investigate causation still begs a question: could the prevailing “policy” of non-investigation of causation of various “medically unexplained” disorders (including Gulf War Syndrome and OP-induced illness) be in any way linked to Government approval, introduced in the 1970s, of using a high-risk organophosphate (pirimiphos-methyl) as an additive for food grains ?

Manufacturers (like Zeneca) had warnings placed on the packaging of their products concerning the dangers of ingesting organophosphate chemicals and the Environmental Working Group in Washington DC called for an immediate ban on their use in agriculture in the United States (see Over-exposed – Organophosphate Insecticides in Children’s Food). In the UK, however, regulators ignored such warnings and the UK Pesticides Safety Directorate upheld approval for the continued use of OPs, advising Ministers accordingly.

Because of this, OP-based insecticides and herbicides were widely used and on orders from central government, if sheep and cattle farmers did not comply with compulsory use of OPs, they were prosecuted.

In 1951, the Zuckerman report on organophosphates had advised that the words “DEADLY POISON” should be printed on all product labels. Today, however, no such warning is required, despite the fact that our knowledge of the neurotoxicity, immunotoxicity and genotoxicity of OPs is greatly advanced (see Kamel F, Hoppin JA. Review: Association of pesticide exposure with neurologic dysfunction and disease. Environmental Health Perspectives; 2004;112:950-958).

Today, treated grain can be eaten without any holding period after treatment with organophosphates (see <http://www.toxmut.or.kr/data/content.php?id=125>).

In 1999, under the chairmanship of Professor H F Woods, the COTS committee (Committee on Toxic Substances) refused to consider the immunotoxicity of organophosphates (see Report on Toxicity of Chemicals in Food, Consumer Products and the Environment published by the Department of Health, 1999). Such refusal is remarkable, given the research material available at the time on the immunological consequences of OP exposure that has recently been reviewed (see Immunotoxicity of organophosphate pesticides. Galloway T, Handy, R. Ecotoxicology:2003;12:345-363).

Organophosphates are immunotoxic in a variety of different ways, including suppression of immune function. Other consequences include hypersensitivity reactions, susceptibility to infectious pathogens, autoimmune responses and cancers of immune cell lines (see *Pesticides and Human Health: A Resource for Health Professionals*. ed: Gina Solomon, (2000) published jointly by Physicians for Social Responsibility and Californians for Pesticide Reform; see also *Pesticides and the Immune System* (chapter 5). Robert Repetto et al (1996) published by World Resources Institute).

Government approval for the continued use of such substances would seem to indicate an apparent willingness to sacrifice vulnerable individuals in order to support policy. If this policy is to continue, the stage is set for major health problems.

How convenient it is if such health problems can be readily dismissed as psychogenic in origin, especially as it is now known that, contrary to the claims of the chemical companies that the active ingredient of organophosphate compounds such as pirimiphos-methyl breaks down within days when diluted in water, there is an apparent increase in toxicity with storage. (see: *Pesticides in Food: the inadequacies of testing*: <http://www.geocities.com/oprus2001/testing.htm>).

In relation to ME/CFS and the serious implications of the dysfunction of immune cells that indisputably occurs in the disorder, one cannot help but call to mind the letter dated 16th June 2000 from Mrs Helen Wiggins at the Department of Health NHS Executive Headquarters in Leeds sent to members of the Chief Medical Officer's Working Group on "CFS/ME"; this letter stressed that it had become increasingly important that any documents or information, in whole or in part, that might contribute to the CMO's report must be kept confidential and to this end, members of the Working Group might be compelled to sign the Official Secrets Act. This was followed up by letter dated 23rd October from Lord Hunt, then Parliamentary Under Secretary of State at the Department of Health, (ref: POH (6) 5380/83), confirming that the information held by the Working Group might in certain circumstances indeed be covered by the Official Secrets Act.

One wonders how the consideration of ME/CFS could rank as a state secret and of what, precisely, is the Department of Health so afraid that it even considered the use of such draconian powers?

For the record, Mrs Wiggins has now been replaced by Robert Harkins and it was Rob Harkins who sent the letter dated 25th May 2004 (ref: TO1056746) in which he stated that the new centres for CFS/ME (quote) "will be headed up exclusively by psychiatrists". Was this a subconscious slip of the pen, or more evidence of support for Government "policy"?

Returning to the issue of the MRC trials on "CFS/ME", would Peter White be kind enough to explain how a psychotherapy regime that includes forced exercise programmes and mind-altering techniques designed to brain-wash patients that they do not have an organic disorder can reverse increased neutrophil apoptosis seen in ME/CFS that occurs in patients with infection and a toxic state ?

Given the concept put forward by Peter White in the *British Journal of Psychiatry* debate (that "the concept of a general functional somatic syndrome is unhelpful in understanding illness, aetiology, treatment and outcome"), how does he square this concept with his current

MRC research position that patients with fibromyalgia should be included with those with myalgic encephalomyelitis? Should he not practice what he preaches?

The British Journal of Psychiatry (2004) 185: 95-96

IN DEBATE

There is only one functional somatic syndrome*

[View](#)

[Further Articles](#)

[Home](#)