pancreolauryl test is being under-used in the investigation of older patients.

The prevalence of pancreatic insufficiency in the older population is unknown. It is now easy to investigate and treat with enzyme supplementation, and should be considered in the differential diagnosis of weight loss in older patients.

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References

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Cost-effectiveness of cognitive behaviour therapy for patients with chronic fatigue syndrome

Sir,

In their economic evaluations of treatments for chronic fatigue syndrome (CFS), Severens et al.1 compared the cost-effectiveness of cognitive behaviour therapy (CBT) with those of other interventions, and found that the percentage of CFS patients who improved with CBT performed for 8 months was 31% vs. 9% and 12% for other treatments. Considering that, in one study, 28% of CFS patients treated with low-dose hydrocortisone over just one month virtually recovered,2 Severens et al.1 also should have compared the cost-effectiveness of CBT with that of low-dose hydrocortisone.

Treatment with low-dose hydrocortisone for CFS, besides being intuitively far less costly than CBT, is also better-founded clinically than any psychological therapy, because hydrocortisone corrects the hypocortisolism that characterizes at least some CFS patients.3 Given that ‘frank hypocortisolism’, rather surprisingly, was one of the exclusion criteria for enrolment in the trial of Cleare et al.,2 the percentage of CFS patients who can be effectively treated with low-dose hydrocortisone in day-to-day health care is likely to be higher than the 28% found in that trial.2

In view of the 42 clinical features that CFS shares with Addison’s disease,4 including all the physical and neuropsychological symptoms listed in the diagnostic criteria for CFS,4 this syndrome should be treated with the two classic drugs for Addison’s disease, namely, hydrocortisone in combination with fludrocortisone,5 not with CBT. This psychological treatment was of benefit only to some patients fulfilling arbitrarily modified criteria for CFS, which ignore the physical signs and symptoms that discriminate CFS from depression.4 Therefore, CBT may have actually benefited depressed subjects, rather than patients with CFS.4

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References

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Cost-effectiveness of cognitive behaviour therapy for patients with chronic fatigue syndrome

Sir,

I read Severens et al.'s article on the cost-effectiveness of cognitive behaviour therapy for patients with unexplained chronic fatigue with interest, although as several subjects met the CDC criteria for 'idiopathic chronic fatigue' rather than 'chronic fatigue syndrome', I prefer to use the term 'unexplained chronic fatigue' as defined by Fukuda et al. to describe the patient sample under consideration.

To be able to regard the presented cost estimates as a valid reflection of the medical costs of patients with unexplained chronic fatigue, it is imperative to demonstrate that there are no differences between participants who are included in the analysis and participants who are excluded from the analysis.

According to the authors: 'An extensive comparison between participants in the cost-effectiveness analyse (n=171) and the remaining clinical study participants (n=99) did not reveal any statistically significant differences regarding age, duration of CFS complaints, and scores for Sickness Impact Profile, Karnofsky score, physical activity, a self-efficacy scale, a causal attribution list, and functional impairment.' (pp. 158–9).

Although details are lacking in the article, baseline data of the included and excluded participants are available from a publication of the Health Care Insurance Board of the Netherlands (College voor zorgverzekeringen). Comparing baseline variables of the two groups using two-tailed independent sample t-tests yields the results that are presented in Table 1. The table shows that physical activity (measured by a motion-sensing device called the actometer), self-efficacy, and psychological well-being (measured by the symptom checklist 90) are significantly different at the 0.05 level. The p values for physical activity (p=0.0081) and self-efficacy (p=0.0046) are particularly small. As the authors did not correct for multiple comparisons when analysing the primary outcome measures in the clinical part of the study, I did not apply such a correction here either.

Because the authors’ statement that there are no statistically significant differences is in contradiction with the two-tailed independent sample t-test results discussed above, it would greatly enhance the reproducibility and external validity of the study if the authors could provide the reader with information on the methods used to compare the included and excluded participants.

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Table 1 Comparison of included and excluded participants in the cost-effectiveness analysis: baseline data from Van Essen et al.

<table>
<thead>
<tr>
<th></th>
<th>Included (n=171)</th>
<th>Excluded (n=99)</th>
<th>Estimated difference</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age in years</td>
<td>37.5 (10.1)</td>
<td>35.3 (9.99)</td>
<td>2.2 (−0.30 to 4.70)</td>
<td>0.0845</td>
</tr>
<tr>
<td>Duration in years</td>
<td>6.0 (5.9)</td>
<td>4.9 (5.1)</td>
<td>1.1 (−0.30 to 2.50)</td>
<td>0.1224</td>
</tr>
<tr>
<td>CIS fatigue</td>
<td>51.8 (4.3)</td>
<td>52.7 (3.3)</td>
<td>−0.9 (−1.89 to 0.09)</td>
<td>0.0733</td>
</tr>
<tr>
<td>SIP total</td>
<td>1766 (589)</td>
<td>1909 (653)</td>
<td>−143.0 (−295.5 to 9.5)</td>
<td>0.0659</td>
</tr>
<tr>
<td>Karnofsky</td>
<td>71.3 (7.5)</td>
<td>70.8 (8.9)</td>
<td>0.5 (−1.50 to 2.50)</td>
<td>0.6228</td>
</tr>
<tr>
<td>Physical activity</td>
<td>63.5 (20.4)</td>
<td>70.8 (23.7)</td>
<td>−7.3 (−12.69 to −1.91)</td>
<td>0.0081</td>
</tr>
<tr>
<td>Self-efficacy</td>
<td>15.1 (3.4)</td>
<td>13.9 (3.2)</td>
<td>1.2 (0.37 to 2.03)</td>
<td>0.0046</td>
</tr>
<tr>
<td>Somatic attributions</td>
<td>13.9 (2.6)</td>
<td>13.7 (2.5)</td>
<td>0.2 (−0.44 to 0.84)</td>
<td>0.5373</td>
</tr>
<tr>
<td>Focusing on bodily symptoms</td>
<td>29.6 (7.4)</td>
<td>31.1 (6.7)</td>
<td>−1.5 (−3.28 to 0.28)</td>
<td>0.0979</td>
</tr>
<tr>
<td>Symptom checklist 90</td>
<td>165 (37)</td>
<td>175 (40)</td>
<td>−10.0 (−19.48 to −0.52)</td>
<td>0.0388</td>
</tr>
<tr>
<td>EuroQol</td>
<td>42 (15)</td>
<td>44 (17)</td>
<td>−2.0 (−5.92 to 1.92)</td>
<td>0.3159</td>
</tr>
</tbody>
</table>

Data are means (SD), or means (95%CI) for differences.