term specialist care. There is some evidence that where community mental health teams routinely follow up all identified patients with major mental illness they are less able to respond quickly when really needed for patients with more acute and more difficult problems.[4]

It seems unlikely that the numbers of mental health professionals working in community teams will increase greatly. A more efficient way of providing community care may involve general practitioners monitoring the more compliant and stable patients (perhaps with a specialist review every few years) while the mental health team concentrates on those patients with greatest needs. By no means all of these patients have psychotic illnesses.

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Presentations of pituitary insufficiency and Addison's disease in insulin dependent diabetes may be similar

EDITOR,—We agree with Lynne Armstrong and Patrick M Bell that a high degree of suspicion is required to diagnose Addison's disease[1]; we too have encountered falling insulin requirements and recurrent severe hypoglycaemia as a presentation of Addison's disease in insulin dependent diabetes.[2] Addison's disease is not, however, the only cause of glucocorticoid deficiency: pituitary insufficiency may present as falling insulin requirements and recurrent hypoglycaemia in insulin dependent diabetes.[2] Unlike in Addison's disease, however, glucocorticoid deficiency in pituitary insufficiency does not present with pigmentation, the electrolyte disturbances of hyponatraemia and hyperkalaemia, and mild uraemia. Moreover, hypoglycaemia in pituitary insufficiency may be more severe than that in Addison's disease because of coexistent deficiency of growth hormone, another potent counterregulatory hormone.

If glucocorticoid deficiency is not to be missed, clinicians must have a low threshold for performing a short tetracosactrin test in patients with insulin dependent diabetes who have falling insulin requirements; a 30 minute serum cortisol concentration of <550 nmol/l suggests glucocorticoid deficiency and the need for steroid replacement and further investigation.

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Government's expert group has reached consensus on prognosis of chronic fatigue syndrome

EDITOR,—The chronic fatigue syndrome is a complex problem that has attracted a great deal of controversy. Against this background, doctors working for the Department of Social Security and its executive agencies have to give informed and consistent advice. To help in this process I set up an expert group to give me advice on the subject. A consensus view was sought on prognosis and chronicity, which are critical factors in determining a person's entitlement to a benefit or pension.

The expert group was drawn from a range of medical disciplines with an interest in the condition, so that it reflected a range of opinions; it first met on 6 March this year. A consensus emerged on most of the topics discussed. A report of the meeting has been published and circulated to those who have a direct interest in the findings.[1]

Clinical scenarios were identified that represented a good and a poor prognosis. A good prognosis was indicated by:

- A definite history of viral illness (particularly glandular fever) in the presence of an uncomplicated psychological background
- A pattern of evolution towards functional recovery
- An early diagnosis aimed at eliminating associated physical disorders and identifying psychiatric illness and any other complicating psychological or social factors
- A management regimen encompassing physical, psychological, and social elements that concentrates on modification of the person's lifestyle, striking a balance between overactivity and the risks of deconditioning and taking a stepwise approach towards achieving functional improvement while addressing factors such as sleep disturbance.

A poor prognosis was indicated by:

- The onset of symptoms without any clear precipitating factor but set on a complex background of adverse psychological and social factors or occurring after a severe infective illness
- Severe and unremitting symptoms, particularly if lasting for over four years. The presence of multiple symptoms, especially those suggesting somatisation
- Delayed diagnosis and especially self diagnosis, with the patient becoming convinced of a single cause to the exclusion of all others
- A management regimen overemphasising the importance of complete rest or advocating a rapid return to pre-illness levels of physical activity. Failure to recognise the need to treat such features as depressive illness or sleep disturbance.

The report of the meeting is an important document that brings some consensus to an area of controversy; it will be helpful to all those who work with patients with the chronic fatigue syndrome.

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Magnetic resonance imaging is uncomfortable for patients

EDITOR,—I was interested to read Keith Duncan and colleagues' response to Helen Rosenthal's account of her severe distress while undergoing magnetic resonance imaging.[1 2] I underwent magnetic resonance imaging three times last year as part of a drug study (in addition to having undergone it once for diagnostic reasons five years previously). While I had no anxiety about a possible malignancy and as a doctor I had some prior knowledge of the imaging procedure, the procedure is more uncomfortable than some medical staff think. The requirement to keep still for minutes on end while encased inside the scanner leads to a sense of claustrophobia; having undergone scanning both with and without the plastic head mask being used, I can state that the presence of the mask for some 40 minutes greatly exacerbates the feelings of claustrophobia.

The noise is considerable and sufficient to make one feel uncomfortable. I had a vague headache for some hours after each procedure. The platform on which one lies is uncomfortably hard when one is unable to move for minutes on end. The temperature is often quite cool as a result of the air conditioning in the imaging suite.

While many of the discomforts are unavoidable (the feeling of being encased inside the scanner, the noise, and the need to keep still), more could be done to improve physical comfort. An effective pair of earplugs, warm blankets, and much more cushioning on the lying platform would certainly help.

I agree with Duncan and colleagues that old fashioned communication skills and kindness are paramount in putting patients at their ease during what can be a distressing experience. If I as a doctor found magnetic resonance imaging uncomfortable, it must be much more so for a lay person suffering from a fear of the unknown in addition to the physical discomforts of the procedure.

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Advice to authors

We receive more letters than we can publish: we can currently accept only about one third. We prefer short letters that relate to articles published within the past four weeks. Letters received after this deadline stand less chance of acceptance. We also publish some "out of the blue" letters, which usually relate to matters of public policy.

When deciding which letters to publish we favour originality, assertions supported by data or by citation, and a clear prose style. Wit, passion, and personal experience also have their place.

Letters should have fewer than 400 words (please give a word count) and no more than five references (including one to the *BMJ* article to which they relate); references should be in the Vancouver style. We welcome pictures.

Letters should be typed and signed by each author, and each author's current appointment and address should be stated. We encourage you to declare any conflict of interest.

Please enclose a stamped addressed envelope if you would like to know whether your letter has been accepted or rejected.

Letters will be edited and may be shortened.