and who were not currently under treatment. A t test comparing this group and the “recovered” CFS group (at 12 months) shows that the recovered group had similar fatigue levels but significantly worse results (p=0.05) on school attendance and on the “physical functioning” subscale of the child health questionnaire than did the controls.

CFS can have a relapsing–remitting course: some patients self-report recovery, only for the condition to return. Further longitudinal data are required to show that the recovered FITNET patients did not subsequently have a return of their symptoms and disability.

A key feature of CFS is that exertion brings on a range of symptoms, those affected tend to engage in little high-intensity activity to avoid such effects. Information from actigraphy is essential to ascertain whether the recovered CFS patients are truly well or if they have adapted their lives and are engaging in less high-intensity activity (such as sports and dancing) than their healthy peers.

We agree that cognitive behavioural therapy finally encourages individuals to see themselves as “ex-patients”, but maintenance of this self-reported improvement 6 months after the end of treatment suggests that this is the patient’s own and lasting reflection. We regard school attendance as a major indication for recovery, and this outcome measure was validated through external assessment of school attendance.

Kindlon and Joan Crawford both suggest use of actigraphy as an objective outcome measure. Our actigraphic data aided the therapist in tailoring the intervention. Patients with low activity need a different approach from patients with fluctuating activity. The goal of our treatment was reduction of fatigue and increase in school attendance, not increase in physical activity per se. Actual physical activity as measured by actigraphy is not likely to be the mediator of reduction in fatigue.

We do agree with Crawford that the cutoff point of −2 SD for recovery is arbitrary and no standardised criteria exist to define recovery of adolescents with chronic fatigue syndrome. In the appendix, we showed results with −1 SD cutoff points. Although this obviously changed the proportion of patients classed as recovered, it did not change our findings with regard to the relative effect of FITNET compared with care as usual, and therefore it does not alter our main conclusions.

Further longitudinal data are required to determine the tenacity of the initial treatment effect. A paper describing the long-term follow-up results is currently in preparation. This will address Crawford’s concerns about future relapses after initial recovery.

We declare that we have no conflicts of interest.

Joan Crawford
joan.crawford@virgin.net
Chester ME Self Help (MESH) Group, Newton, Chester CH2 2AN, UK


European licensing of maintenance treatment in schizophrenia

The paper by Stefan Leucht and colleagues on antipsychotic drugs for relapse prevention in schizophrenia (June 2, p 2063)1 provides much needed information with which to design clinical trials in Europe. The European Medicines Agency (EMA) is presently reviewing its licensing guidelines for schizophrenia drugs.

The current guidelines1 require double-blind, placebo-controlled studies to show short-term (4–6 week) efficacy for patients in the acute phase. Maintenance of effect can be shown either by...