found that delayed recovery at six weeks was associated with psychological vulnerability in patients who had had influenza, White *et al* (in press) found that only patients with glandular fever, but not other viral infections were associated with fatigue at six months follow up. Wessely *et al* (1995) in a large prospective study, found no evidence that common infections were related to the development of CFS in primary care.

Second, Shanks & Ho-Yen claimed that counselling resulted in an 80% improvement rate. While this result is very impressive the authors failed to provide any data which supports their sweeping conclusion. As one of the defining characteristics of CFS (Sharpe *et al*, 1991) is a 50% reduction in activity levels it is difficult to see how 80% of the group studied could have improved in terms of their disability when they were given advice to live within their limits.

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T. CHALDER

King's College School of Medicine
& Institute of Psychiatry
London SE5 8AZ

AUTHOR'S REPLY: Ms Chalder is correct in saying that our findings do not prove that the evidence of viral infection detected in over half our sample of patients was closely connected with the subsequent chronic fatigue syndrome. In fact we showed that CFS patients with and without associated emotional disorder were biologically similar over a range of viral and immunological measures. This confirmed previous studies which showed that such measures, while they might contribute operationally to clinical definition, have little diagnostic value in this population far less any established etiological significance. Our reference to 'precipitating' viral infection was meant in the sense of association with the onset of symptoms, rather than implying aetiology, which of course could be in either direction.

Counselling to remain within energy limits is not logically incompatible with progressive diminution of the symptoms of fatigue. The detailed findings related to psychiatric diagnosis were not included in our paper, but in this early onset population generalised anxiety and panic disorders were much more frequently identified than the chronic depressive states described in populations with a longer duration of fatigue, and constituted over half the case diagnoses.

Patients with more recent onset of symptoms and a different pattern of associated emotional disorder appear to have a better prognosis. Admittedly this finding is based on a global clinical severity scale and simple data about occupation, although at the time the study was planned, more sophisticated assessments of fatigue symptomatology had not been developed.

M.F. SHANKS

Royal Cornhill Hospital
Aberdeen AB9 2ZH

Blu-Tack – a novel substance of abuse

SIR: We wish to report a novel form of substance abuse, namely the smoking of the adhesive material *Blu-Tack*. Three male patients (aged 23, 27 and 32 years) detained on our semi-secure unit for the chronic mentally ill, all with the diagnoses of paranoid schizophrenia and substance abuse, were found to have been attempting this activity in the enforced absence of their preferred substances.

Two methods were employed. Both commenced with drying the *Blu-Tack* on a radiator for three weeks (or until the experimenter's patience expired). The resulting residue was then either crumbled and smoked with tobacco in a roll-up cigarette, or inhaled from the burning end of a match. One of the three informed us that he experienced a very slight "high" along with a peculiar sensation in his stomach (the latter may however be related to his longstanding somatic delusions), but denied any other effects. Another (the originator, claiming to have thought of the procedure himself) found it to have virtually no effect on him. The third also found it an unrewarding activity. No changes were observed in these patients' mental states or physical conditions as a result of this particular activity.

Neither the hospital pharmacy nor the Regional Poisons Centre had any information regarding this phenomenon, and there does not appear to be any reference to it in the medical literature. The only other report we have heard emanates from HM Prison Saughton (CPN Ian Wishart, personal communication).

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