

## Letters to the Editor

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### Multiple Chemical Sensitivity Syndrome

*To the Editor:* In reference to "Multiple Chemical Sensitivity Syndrome: A Clinical Perspective" Parts I and II by Sparks et al (*J Occup Med.* 1994; 36: 718-737), I take exception to the statement that "Although general consensus was reached on an approach to clinical evaluation and management of MCS patients, the acknowledged contributors and reviewers do not agree on every point." While I was a contributor, I do not concur with the so-called "general consensus" presented in these articles. The first paper, which addresses competing hypotheses for MCS, contains a sufficient number of "mays" and "mights" that it could be described as "technically correct." However, ultimately, the caveats and tentative hypotheses are abandoned when the authors take sides by recommending primarily psychological interventions. To focus primarily on psychological interventions without adequately discussing environmental interventions, as these authors do, is identical to the recommendation that would follow from the conviction that the patients' problems were psychogenic in origin.

When I was invited to be a co-author on this paper, I declined because of its emphasis upon psychological interventions and minimal discussion of the potential role of chemicals and foods in the illness and upon trial-exposure reduction. Sparks aptly describes the "vacuum created by lack of data" on MCS. But when data are lacking, there is no basis upon which to recommend psychological therapies over environmental interventions except the authors' unsubstantiated belief that the patients' problems are psychogenic. Patients often are helped by psychological sup-

port no matter what the origin of their problems, but that support must not substitute for interventions that address possible physiological origins of their problems.

From a recent survey we conducted of 206 MCS patients with an average educational level of almost four years of college, the majority rated avoidance of problem chemicals (71%) and foods (54%) as "very helpful." Fifty-two percent of the 206 respondents had also tried psychological or psychiatric therapies, but only 17% of those who had tried them rated them as "very helpful." These patients, while recruited via announcements in patient newsletters, clearly feel that avoidance of problem chemicals and foods has been more helpful to them than psychological therapies. Where are the clear data upon which Sparks et al base their support for psychological interventions?

Finally, Sparks et al state that "the burden of proof rests with the proponents of avoidance that it is effective in reducing symptoms and is necessary to prevent toxic injury." Given the lack of funding for research on MCS, scientific proof one way or the other is likely to take years. In the meantime, how are patients to prove their need to avoid exposures for purposes of compensation, insurance coverage, or acceptance by the medical community? I can think of no other instance in medicine where we reject what the majority of patients (particularly such well-educated patients) tell us exacerbates and ameliorates their symptoms without first exploring their observations as potentially valuable clues.

While MCS is an understudied condition, data are emerging.<sup>1,2</sup> As a practitioner, I would not wish to be caught in the uneasy position a few

years hence of not having advised patients to avoid exposures to substances that caused them permanent harm. Anecdotal reports of individuals with MCS who were diagnosed early, avoided further exposure, and recovered<sup>3</sup>, suggest that early intervention could prevent long-term disability for some individuals. Perhaps prevention of MCS is where we should be placing our emphasis—once the condition develops, *no* treatment appears satisfactory.

In sum, Sparks et al correctly diagnose the problem—lack of research on MCS—but their recommendations for clinical management are unjustified and simply reveal to the reader, and to the patients by the way, that in spite of their "mays" and "mights," they already have made up their minds. What to do until the data comes? Discuss with patients the possibility of MCS if symptoms and circumstances suggest it. Describe the divergence of opinion in the medical community in an open and honest manner. Discuss treatment options others have used, including psychological support and avoidance strategies, and the lack of peer-reviewed publications containing data as to their efficacy. Maintain agnosticism, while conveying an earnest desire to see patients improve. Schedule ample time for visits and regular visits so patients can discuss their problems and concerns adequately. As Sparks et al correctly observe, "The evaluation of a patient presenting with MCS may take several hours and it is necessary to allot sufficient time, even if inadequately reimbursed."

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2. Miller CS. Chemical sensitivity: history and phenomenology. *Toxicol Ind Health*, in press.
3. Hileman B. Multiple chemical sensitivity. *Chem Eng News*. 1991;69:26-42.