De Editor,


In a recent contribution Goedendorp et al. [1] concluded that underperformance of myalgic ME/CFS patients is associated with worse neuropsychological test performance, and implicate that abnormal test scores are due to suboptimal effort, either consciously or unconsciously.

However, the claim that ‘a substantial subgroup of patients showed evidence of underperformance’ [1] is not reflected in their data: ‘16% (n = 26) of the patients demonstrated underperformance at baseline indicated by a score on the Amsterdam Short-Term Memory Test (ASTMT) of lower than 84’ [1].

The authors assert that ‘a disparity between the prevalence of subjectively and objectively assessed cognitive impairments is often found’. As Cockshell and Mathias [2] and Thomas and Smith [3] concluded, it is essential to employ appropriate tests to reveal the characteristic cognitive deficits in ME/CFS patients or large subgroups thereof. Whether or not the simple and choice reaction time and performance tests appropriate tests to establish cognitive impairment/performance in ME/CFS remains to be established objectively.

Despite contradictory findings, cognitive deficits in ME/CFS are demonstrated repetitively in ME/CFS patients or subgroup thereof [2]. Thomas and Smith [3] e.g. found ‘compelling evidence, not only for the existence of cognitive deficits in ME/CFS, but also for the nature of these impairments’. The deficits remain even when performance impairments are taken into consideration. Cognitive deficits can plausibly be explained by organic abnormalities, e.g. reduced cortical blood flow/hypoperfusion and metabolic dysfunction [4].

The ASTMT is not an objective instrument to establish underperformance, since the ASTMT implicates a priori judgment that low scores are due to ‘proven cognitive disorders’ [1]. If one believes that cognitive impairment in ME/CFS is not the result of a proven cognitive disorder beforehand, deviant neuropsychological test performance can be explained by underperformance at the ASTMT by definition. The hypothesis that low scores on cognitive tests are due to underperformance using the ASTMT combined with the premise that ME/CFS is not a proven cognitive disorder is an example of circular logic.

The authors also observed that presumed underperformance was associated with more disabilities, both before and after treatment, and related to worse neuropsychological test scores. An alternative hypothesis is that cognitive impairments in ME/CFS can be identified objectively if appropriate measures test are used [3] and the premise that ME/CFS is not a cognitive disorder is invalid. Objective tests for assessing intention, effort and underperformance, e.g. the Validity Indicator Profile [2], should be used to establish underperformance in ME/CFS.

In this context it also seems relevant to make a distinction between ME (CFS with post-exertional malaise: a long-lasting increase of symptoms after a minor physical or mental exertion) and “CFS” (CFS without post-exertional malaise), since post-exertional malaise seems to be correlated with concentration deficits and elevated levels of inflammatory markers [5].

In conclusion, underperformance of ME and CFS patients at neuropsychological tests should be assessed objectively without a priori judgments about the etiology. The evidence at present doesn’t support the thesis that cognitive deficits found are due to underperformance in a substantial CFS or ME patient subgroup.

Conflict of interest

The author declares no conflict of interest and approves the manuscript.

References


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