

Multiple Chemical Sensitivity Review – Draft Report 2008-09

Comment

1. Corrections

- a) p.10 CNS not listed in Abbreviations p.5 (but noted in text p.15 as Central Nervous System)
- b) p.14 1st para 'caused MCS' should be 'called MCS' ?
- c) p.17 Last sentence is tautological.
 - Either – It is anticipated that... findings... are to be published.
 - Or – ... findings... are expected to be published.
- d) p.56 SBS not listed in Abbreviations p.5 (should be MCS?)

2. Statements Challenged

- a) pp.6-8
 - (i) The recognition of smells or odours relies on molecules of a substance reaching the olfactory system. Such molecules must retain any pharmacological or toxicological properties of that substance.
 - (ii) Having an aversion to smells or odours is totally different to having a reactive dysfunction continuing for days and weeks before subsiding.
 - (iii) Disruption of normal function occasioned by an odour confirms the extremely low dose required to initiate symptoms.
 - (iv) It is a feature of MCS that dose responses are atypical.
 - (v) Some incitants are odourless, or virtually so. As the prime carer of a diagnosed MCS spouse, I have been able to detect a sprayed pesticide application 600 metres distant by a slight nasal irritation and a taste on my palate, rather than a distinctive odour.
- b) p.9

The WHO has not endorsed IEI. The IPCS report includes disclaimers to that effect. Only the 1996 Workshop participants, many of them allied to chemical companies, favoured the descriptor IEI over MCS.
- c) p.14

That a single multiple-organ disorder can be attributed to the entire spectrum of symptoms resulting from an exposure to a chemical cannot necessarily EXCLUDE an MCS condition. That exposure may be the initiator of MCS; additional disparate triggers will point to MCS as the diagnosis.
- d) p.30

3rd para "...no evidence of accumulation of toxic chemicals in MCS subjects has been found."

This does not correlate with the many instances of warnings in Material Safety Data Sheets of accumulating effects of some agricultural toxins via multiple exposures. The chemical industry must have evidence of non-metallic toxins accumulating in subjects exposed to these formulations, particularly those classified as persistent – for example synthetic pyrethroids such as deltamethrin.

3. Queries

a) p.16 2.7 DO INDIVIDUALS WITH MCS SHARE COMMON CHEMICAL EXPOSURES?

Is this section asking if MCS subjects are exposed to chemicals in common with others? Or is it asking which chemical exposures commonly provoked reactions in MCS subjects? The data collection is overwhelmed by an occupational bias. Only *Ashford and Miller's* 1998 groupings refer to individuals. Even so I would prefer it to be worded "Individuals who receive a debilitating exposure to a chemical unexpectedly." Unless their group did not include those persons subject indirectly to industrial, agricultural, commercial and private emissions of toxins, solvents et al, especially children of those ages when immunity is still developing.

b) p.37 It would be helpful if the benefits allegedly experienced by MCS patients to education, support and acknowledgement could be tabled in a similar manner to that of the HREOC recommendations (also p.37). Acknowledgement is certainly long overdue from Governments.

4. Additions

a) p.8 Last para. There is indeed a need for better public information in order to address concerns regarding MCS. The list of recipients in most need of guidance on appropriate help and assistance for MCS people should include Federal and State Agencies having responsibility for health safety, and local governments. In spite of existing legislative demands, which includes the Precautionary Principle, these agents steadfastly refuse to institute practical ways to assist people affected by MCS. The Dept. Of Health and Ageing, the Office of Chemical Safety and the Minister must now accept MCS as a disabling entity, irrespective of its undetermined aetiology. The HREOC's example must be emulated by an issue of guidelines and recommendations on the basis of the only known viable therapy – avoidance of potential triggers. For example: a voluntary public register of sensitive locations (MCS people, organic farms et al) held by local governments would assist commercial and citizen pest controllers in providing prior notification of toxic releases.

b) p.13 DBPC challenges must consider that adverse reactions are not always immediate – nor are recoveries. There may be a time lapse before symptoms become evident, and most likely there will be a considerable time lapse before symptoms clear – **IF** actually they ever do fully dissipate.

Terminology

p. 25 In the realm of hypotheses, theories or suggestions, researchers should resist definitive statements. eg. Not, MCS **is** – rather, MCS **may be** iatrogenic.

When most GPs generally are ignorant of MCS, are baffled by the plethora of symptoms displayed, have no idea of a treatment to offer and dismayed by a lack of significant results from a battery of standard tests, iatrogenic influence seems remote.

A perspective

Retrospectively based on the life of a seventy-two year old female MCS subject.

1941 The genesis of this condition most likely occurred when she was shifted from semi-rural surroundings into the steel-making environment at the age of four years. From that time she has suffered a continuum of malaise and fatigue that for many decades remained undiagnosed.

Conclusion

This accords with the proposal that a STRESSOR is part of the pathogenesis of MCS.

In general, GPs and specialists consulted were baffled by the symptoms, the failure of standard tests to point to a cause, and in some cases offered an opinion that pesticides were harmless to humans. Treatments applied were aimed at relieving symptoms, not always successfully and occasionally exacerbating the discomfort.

Conclusion

This mitigates against iatrogenic influence.

As the subject matured the reactions (symptoms) became more severe and recovery times extended.

1974 The ability to sustain employment had degenerated sufficiently to warrant placement on the Disability Pension.

1981 Brought a diagnosis of ME/CFS. The process of compiling a medical history for this consultation led to a recognition of patterns to the onset of symptoms, patterns not entirely consistent with CFS. Connections were made with paint solvents, petroleum derivatives, perfumes, fly sprays and third party use of pesticides and herbicides, synthetic fibres and commercial foods.

Conclusion

That chemicals are a prime trigger of health deteriorations.

1984 Constant illness forced husband to accept a Carers Pension as a full-time principal carer. (New home energy mostly natural gas).

1989 Asthma initiated following a series of glyphosate applications by the local council, unannounced in spite of requests for notification. Other reactions to glyphosate are a lapse into unconsciousness and convulsions. On initial "recovery" a loss of comprehension, speech difficulties, incorrect selection of words, uncharacteristic sentence constructions, handwriting enlarged and spidery.

Conclusion

Symptoms tabled on p10 of Draft are understated. Confusion and memory problems do not

convey the enormity of neurological damage and functional deficits that can be experienced.

1998 Dr Mark Donohoe and Assoc. Prof. Chris Winder both confirmed a diagnosis of MCS and CFS (or Chemically Related Chronic Fatigue Syndrome).

Avoidance of chemicals is, of necessity, the prime defence strategy, a life separated as much as is possible from a chemically addicted community. A protective mask against VOCs is donned for any foray into the public domain. Both carer and subject are constantly alert for any chemical spraying activity, bituminous roadworks, painting activity, vehicles carrying plastic tanks, backpack tanks, aerosol cans etc.

Conclusion

Any psychological disorders or fears are generated after the onset of MCS and experience of shattering reactions, and generally well before any formal recognition of the condition.

Comment

On Idiopathic Environmental Intolerance IEI

'Idiopathic' – of unknown cause, may be considered scientifically correct, yet there is no doubt that thousands of victims across the planet consider a chemical exposure to be the trigger of their discomfort and disability, whether or not the cause is eventually described as a complex association.

'Environmental Intolerance' – is a descriptor suitable for aliens. It will alienate those who realize that the problem comes in a socially produced impregnated micro atmosphere containing the intolerable substance, natural or concocted.

The appellation MCS has been popularly adopted worldwide.

Two thirds of the reference papers cited in the Review include chemical sensitivity in the title.

It is an apt descriptor which does NOT propose a pathogenesis but merely attributes a catalytic agent. (Except, perhaps, to those sensitive to profit loss.)

Appeal

Until the cause is scientifically determined let MCS remain the descriptor for this condition. Let the condition be recognised officially and accepted as a legitimate disabling health problem, and one relevant to existing health protection legislation.

In Victoria, State Legislation and Policy demands protective preventative action on environmental health dangers, and control of health problems affecting particularly vulnerable population groups; even specifying the isolation of affecting factors, and interventions if health is affected.

I refer to the Health Act SS40,41,29A, the Agricultural and Veterinary Chemicals (Control of Use) Act S1, the Environment Protection Act SS41 and 59E, the Occupational Health and Safety Act SS23,24 and the State Environment Protection Policy clauses 7(2)(a), 7(5)(b), 7(6)(a), 7(10), 7(11)(b), 8, 9, 12(1), 13(1), 13(2), 14(2), 15(2).

Unaccountably those agencies responsible for administering these policies resist regulating controls for chemical releases into the atmosphere simply because the mechanism of MCS has yet to be described. Yet the dramatic aftermath can be observed, and described, as a sudden loss of well-being involving pain and discomforts both physiological and psychological. The latter, in part, from being aware that legislated interventions are being deliberately withheld.

The Material Safety Data Sheets of toxic chemicals list the symptoms likely from exposure to that compound, and the first aid procedures to be followed. Yet the general bystanding public rarely, if ever, are given an opportunity to peruse these.

The APVMA warns users of certain registered product to avoid inhalation or contact with the formulation, and of the vulnerability of wildlife, farm stock or crops, bees, fish and water bodies, yet refuses to warn of dangers to human bystanders from spray drifts or vapours.

It seems that the potential for damage is realized and accepted only for anything attached to user economic profit. Government agencies condone this attitude by default. State Policy explicitly declares that persons who generate pollution and waste (spray drift is both) should bear the cost of containment, avoidance or abatement. [SEPP 7(5)(b)]

A scientific review must include an assessment of observations in the field, and no observation must be ignored.

I call upon the Minister, the Dept. of Health and Ageing and the Office of Chemical Safety to ensure this abrogation of State Policy and legislation is halted at the next COAG meeting.

This Review makes it evident that the most practical assistance to self-management of MCS, when no medical therapy is proven, comes from prior notification of chemical applications combined with appropriate regulation and other interventions, as legislated.

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