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Pseudo food allergy

Food avoidance—from simple dislike at one extreme to specific food fads and anorexia nervosa at the other—may be excused by patients as "allergy." The deliberate stimulation or simulation of anaphylactic emergencies is a variant of the Munchausen syndrome,[1] and the parental infliction of supposed allergies on their child is a variant of Meadow's syndrome.[2] The false conviction that they have a food allergy is by no means rare in adult patients—and in many cases it puts their health at risk.

True food allergy does occur, and double blind feeding tests[3-7] have confirmed all of its classical features.[8] The same tests have failed to support claims that food allergy is the basis of many other common disorders and have indicated that apparent reactions to food are quite often of psychological, rather than organic, origin.[9] Modern immunological techniques have shown that false conclusions may be drawn by clinicians unaware of the frequency of non-immunological organic responses. Anaphylactoid reactions to common food additives may lead to a false suspicion of allergy to natural foods. Sensitivity to sulphur dioxide and to sulphur dioxide generating sulphites is a regular manifestation of the bronchial hyper-reactivity of asthma[10-12]; sensitivity to azo food dyes and benzoate preservatives appears to occur in a distinct, but poorly defined, syndrome.[13-14]

Clearly, then, we need to distinguish psychologically induced physical changes in patients with true allergic disease and apparent reactions to food as a feature of psychiatric disturbance. The former are another manifestation of the hyper-reactivity of end organs in atopy, they commonly occur in the absence of any psychopathology, and they may simply be a feature of the non-specific autonomic arousal of emotional states—although they may also be induced by suggestion[15 16] or become a conditioned reflex.[17]

By contrast, the victims of pseudo food allergy suffer from a range of underlying psychiatric problems[18] but present with an initially confusing array of symptoms referable to multiple organ systems.[9 19] Careful history taking will uncover variable combinations of physical symptom complexes such as the somatic concomitants of depression and anxiety; features of the irritable bowel syndrome, sometimes with typical associated urinary symptoms; and the protean manifestations of chronic hyperventilation, which commonly include atypical chest pains, palpitations, dizziness or fainting, muscle weakness or spasms, and sensory dysaesthesiae such as itching, burning, or "swelling."[20 21] Associated dyspnoea has sometimes been misdiagnosed as asthma.

Commonly these patients become convinced that they have allergies as they become dissatisfied with the medical care they are getting. Sadly, all too often this dissatisfaction is the result of misdiagnosis, mismanagement, or poor communication by their orthodox doctors. Subsequently—and encouraged by the recent spate of misleading coverage by the media and unable to find an allergy specialist in the National Health Service—these patients resort to self diagnosis using popular books or turn to the blossoming number of private alternative allergy or "ecology" clinics, with their dubious diagnostic techniques ranging from cytotoxicity and provocation neutralisation testing to divination.[22] Much of the publicity of the ecology clinics expressly reinforces these patients' pre-existing belief that use of the term psychosomatic in orthodox medicine is an insult implying that their symptoms are entirely imaginary.

Once patients become convinced that they have unidentified allergies particular foods may then become incriminated through coincidental exacerbations or from the results of supposed allergy tests. Some go on to develop psychogenic, usually hyperventilatory, responses to specific foods. These foods are then excluded from the diet—and the patient then enters a cycle of progressively avoiding many foods and relapses after the initial placebo effect of each new exclusion. The end result may be a serious risk of malnutrition.

Successful treatment of this problem depends on its recognition and the proper treatment of the true cause of the symptoms. Somatic features such as early morning waking, diurnal variation in mood, and disturbances of appetite and energy or libido, or both, justify a therapeutic trial of a tricyclic antidepressant. The hyperventilation syndrome is easily confirmed by reproducing the patient's symptoms by voluntary overbreathing and by relieving them by rebreathing into a bag. Demonstration and sympathetic explanation of the organic but non-dangerous nature of these frightening symptoms is often the only treatment necessary. Patients with the irritable bowel syndrome need to be convinced that their doctor accepts they have a "real" condition despite the absence of dangerous pathological lesions. If the patient advances overvalued ideas of allergy these are likely to be resistant to rational argument and the most practical course may be simply to prevent deficiency diseases by giving appropriate dietary supplements.

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The epidemic of pseudo food allergy demands better professional education and public dissemination of accurate information about allergy. Much recent press and television coverage has been heavily influenced by public relations campaigns on behalf of fringe groups providing better television than science. Education, research, and proper treatment of patients with hypersensitivity diseases would be much aided by the overdue recognition in Britain of allergy as a proper clinical subspecialty and the establishment of a recognised training programme.

DAVID J PEARSON

Senior Lecturer in Medicine,
University of Manchester,
Research and Teaching Block,
West Didsbury M20 8LR

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Domiciliary consultations within the pain relief service

The cardinal rule of all pain clinics is that pain should not be treated symptomatically if there is a definitive treatment for the cause of the pain.[1] Usually, however, patients with intractable pain referred to a pain relief specialist either have chronic pain with no definitive diagnosis or, if there is a definitive diagnosis, no treatment for the cause of their pain. In such circumstances chronic pain is raised to the dubious dignity of a disease and is treated symptomatically.

The doctors who run pain relief services in England and Wales are mainly anaesthetists, but the scope of their work makes them specialised "general practitioners." There were 2681 domiciliary consultations by anaesthetists in England and Wales from 1 October 1983 to 30 September 1984, with around 328 anaesthetists in England and Wales providing pain relief services.[2,3] Anaesthetists would rarely be asked to provide a domiciliary consultation for any other reason, and all these consultations may be assumed to be for pain relief. There are 1827 consultant anaesthetists in England and Wales; arithmetic shows that 18% of them are providing a pain relief service and that they average eight domiciliary consultations a year.[2,3]

A recent review of domiciliary visits for the relief of pain reported the results of 300 visits over 19 years.[4] Of the pain problems referred lumbago or sciatica accounted for 241 (77%), thoracic pain 21 (7%), terminal care 25 (8%), and others 23 (8%)—figures similar to outpatient referrals to a pain clinic. Two hundred and seven (69%) of the patients were treated at the visit, most (174) having caudal injections of procaine. Although the possible side effects and the facilities for treating side effects were mentioned, no incidence of side effects was reported. Published reports suggest that convulsions may sometimes occur after caudal injections of the amide local anaesthetics.[5] The authors chose procaine, an ester, because of its low toxicity—but it has the highest incidence of allergy of all local anaesthetics.[6] Many anaesthetists would consider that major regional nerve blockade should be performed only when full facilities are available for resuscitation—in a hospital.[7] Furthermore, one of the original reports of caudal injection for low back pain showed that procaine and saline produced similar results when injected in the caudal hiatus.[8] That does not mean that all local anaesthetic blockade is contraindicated in the home: the simpler more peripheral diagnostic and therapeutic nerve blocks use a much smaller volume of local anaesthetic and are not associated with the same complications as the major central nerve blocks.

The advantages to the patient of a domiciliary visit are obvious. The home visit also has advantages from the point of view of the doctor, in that assessment in the home environment is likely to be more reliable.[9] The treatment given to such patients should be limited, however, to the simple peripheral nerve blocks because there has to be some trade off between safety and efficacy. Any financial advantage to the NHS from domiciliary visits is likely to be small even if the patient would otherwise have been sent to and from hospital by ambulance.

C J GLYNN

Consultant Anaesthetist,
Oxford Regional Pain Relief Unit and
Pain Relief Research Unit,
Abingdon Hospital,
Abingdon OX14 1AG

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