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.

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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.

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