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A SIMPLE WEIGHT-REDUCING DIET

BY

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Fifteen years ago I devised a reducing diet, and have since used it for a large number of patients. The essential instructions are as follows:

1. Eat or drink as much as you like (or can get) of :

Lean meat, poultry, game, rabbit, hare, liver, kidney, heart, sweetbread—cooked in any way, but without addition of flour, breadcrumbs, or thick sauces.

Fish (not tinned), boiled or steamed only ; no thick sauce. Eggs, boiled or poached only.

Potatoes, boiled, steamed, or baked in skins, but not fried, roast, sauté, or "chips" ; not potato powder.

Other vegetables of all kinds (fresh, tinned, or dried) cooked in any way not involving the use of fat.

Salad and tomatoes without oil or mayonnaise.

Beetroot, radishes, watercress, parsley.

Fresh fruit of any kind, including bananas. Also bottled fruit if bottled without sugar. Not tinned or dried fruits (including dates, figs, and raisins).

Sour pickles, not sweet pickles or chutneys.

Clear soup, broth, "bovril," "oxo," "marmite."

Salt, pepper, mustard, vinegar, Worcester sauce (no other sauces).

Saccharin for sweetening.

Water, soda-water, and non-sweetened mineral waters.

Tea and coffee (milk only as allowed below).

2. You may have milk (not condensed) up to half a pint (284 ml.) daily. No cream.

3. You may have three very small pieces of bread per day and take them either one at each main meal or all three at one meal as desired ("very small" means not exceeding 1 oz.—28 g.).

4. You may have *nothing else whatever* ; particularly note that this means :

No butter, margarine, fat, or oil (except for cooking meat, not fish).

No sugar, jam, marmalade, honey, sweets, chocolate, cocoa.

No puddings, ices, dried or tinned fruits, nuts.

No bread (except as above), cake, biscuits, toast, patent reducing breads, cereals, oatmeal, "all-bran," "ryvita," "vitawheat."

No barley, rice, macaroni, spaghetti, semolina, sausages, cheese.

No cocktail savouries, alcohol (beer, cider, wines, and spirits).

Weigh before you begin, and thereafter weekly, on the *same scales*, in the *same clothes*, and at the *same time* of day.

The general principle of the diet is simply to allow unrestricted consumption of specified low- and moderate-calorie foods, with measurement of only two foods, milk and bread. It is therefore very simple, and patients generally report it as easy to carry out, even in these days, whether eating at home or in restaurants or as guests.

The opening words "eat or drink as much as you like" seem to predispose to willing co-operation. Encouragement to eat unlimited potatoes generally occasions pleasant surprise. The lay public has deeply rooted the notion that potatoes are more fattening than anything else and, consequently, the obese have usually been denying themselves potatoes, which, in fact, are not of high calorie value unless covered and impregnated with fat in cooking. Obese subjects can eat liberal helpings of boiled, steamed, or baked (without fat) potatoes three times a day and still continue to lose weight.

Weight lost by patients who adhere faithfully to the diet, without any lapses, varies from 15 to 35 lb. (6.8 to 15.9 kg.) in 12 weeks. More can be lost (up to 60 lb. (27.2 kg.) in the very fat) by going on. Prolonged experience enables one to say that a patient with simple obesity who does not lose weight is eating or drinking outside the permitted articles.

After weight reduction has been achieved the patient is left knowing the foods which are most fattening. He or she should be advised to return to ordinary diet but to maintain weekly weighing and check any observed tendency to regain weight by moderate restriction of consumption of the articles listed in Instruction 4.

Hitherto I have not had the diet printed, except for hospital use, but in response to requests from practitioners I have arranged with Messrs. H. K. Lewis & Co., Ltd., 136, Gower Street, W.C.1, to produce it as a printed diet card with the instructions on the front and the weight record on the back. (Price 7d. post free.) The instructions are prefaced by a warning that the diet should not be undertaken except on the advice and under the supervision of a doctor. A footnote states that the card is intended for sale only to registered medical practitioners.

Medical Memoranda

Pylorospasm in the Adult, Complicated by Uraemia

In the *B.M.J.* of Jan. 17, 1948 (p. 99), Mr. A. Hobson mentions the connexion of hypertrophic pyloric stenosis with uraemia. I have recently treated a case similar to his, although mine was undoubtedly pylorospasm instead of true hypertrophic stenosis.

In Price's *Practice of Medicine* (1938) it is remarked that "spasm is often stated to give rise to pyloric obstruction, but the evidence that it can do so is inconclusive, except in the hypertrophic pyloric stenosis of infants." In contrast to this, Beckman (U.S.A.) in his *Treatment in General Practice* under the headings of "nervous dyspepsia" and "pylorospasm" describes cases very similar to that of my patient.

CASE REPORT

In January, 1916, while in the Army, a professional man now aged 60 had jaundice with acute pain and was in hospital for four months. In September, 1916, he underwent appendectomy for alleged chronic appendicitis, and has suffered from flatulent dyspepsia ever since. He was first seen by me in December, 1919, when he had a temperature of 102° F. (38.9° C.) and a much-enlarged and tender gall-bladder.

In January, 1927, he still had flatulent dyspepsia, and cholecystography on two occasions failed to show the gall-bladder. The report on a barium meal was that the first, second, and half the third part of the duodenum were enormously dilated, possibly by obstruction by the superior mesenteric artery. On my advice an exploratory laparotomy was done. The gall-bladder was removed, but was found to contain no calculus and did not seem to be unhealthy. From this time flatulent dyspepsia had persisted more or less continuously with bouts of vomiting. Barium meals on several occasions showed no abnormality of stomach or duodenum. In March, 1946, he had jaundice with relapse, presumably due to infective hepatitis, which was epidemic at the time. During the summer of 1947, while on holiday in England, he was very ill, vomiting frequently and losing a great deal of weight. He was admitted to hospital, and after barium and fractional test meals was told he was suffering from "cramp of the stomach," which in the light of recent events presumably meant pylorospasm.

I saw him in October, 1947. He was then extremely thin, but stool culture revealed nothing abnormal. By the middle of January, 1948, he had been free of symptoms for three months, had been eating less carefully than for a long time, and had gained some 18 lb. (8.2 kg.). This ruled out any possibility of carcinoma. It was quite evident that his symptoms were closely related to worry, of which he had been free during these three months. On Jan. 20 he relapsed. He now restricted his food, but had vomited several times daily for a week. His subsequent history is as follows:

Jan. 22.—Still vomiting; mental confusion and delusions. Admitted to hospital. Urine: a few granular and hyaline casts; traces of albumin; sp. gr. 1014. Blood urea 172 mg., plasma chlorides 415 mg. per 100 ml.

Jan. 23.—No more vomiting. Urine 14 oz. (400 ml.). Rational at times. B.P. normal. Glucose-saline, 500 ml. b.d. subcutaneously; orange juice, etc.

Jan. 24.—No vomiting. Great mental confusion.

Jan. 25.—No vomiting. Urine, 70 oz. (2 litres). Blood urea, 200 mg. per 100 ml. No noteworthy change occurred for five days.

Jan. 30.—Urine, 70 oz. Blood urea, 72 mg. per 100 ml.

Feb. 1.—Urine, 30 oz. (850 ml.). Vomited copious green fluid several times.

Feb. 2.—Urine, 34 oz. (965 ml.). Copious vomiting.

Feb. 3.—Copious vomiting of green liquid. On inspection very strong peristaltic waves visible in epigastrium, with a swelling as large as a tangerine orange progressing towards the pylorus, as seen in congenital pyloric stenosis of infants. Barium meal: on screening, very strong peristalsis of stomach with antiperistaltic wave after it had reached the pylorus. Two-and-three-quarter hours later no barium had passed the pylorus. Atropine 1/100 gr. (0.65 mg.) subcutaneously; "bellafoline" 10 minims (0.6 ml.) t.d.s.; phenobarbitone $\frac{1}{4}$ gr. (50 mg.) t.d.s.; glucose-saline 500 ml. b.d.

Feb. 4.—No vomiting. Urine, 20 oz. (570 ml.).

Feb. 5.—No vomiting. Atropine, 1/200 gr. (0.32 mg.) b.d.

Feb. 6.—Copious vomiting. Atropine and bellafoline discontinued. "Antal" 10 ml. I.V. daily for 18 days. (Antal is a French preparation containing 1 mg. of atropine and some sodium bromide.) It was noticed that the very violent peristalsis of the stomach which occurred after the ingestion of any food ceased in a few minutes after the injection of antal; the patient then announced that the spasm had relaxed, and food was passing the pylorus.

On Feb. 20 he was eating cold chicken and ham without inconvenience and had returned to work in his office.

Nov. 10.—For four months past he has been free of all symptoms, eating normally, and feels better than he has done for 25 years.

I believe the "cure" to be due to his realization that the gastric trouble was due to psychological causes.

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Sternal Swelling as a Presenting Sign of Hodgkin's Disease

The association between sternal swellings and Hodgkin's disease has been noted by Goldman and Victor (1945) and by Sicher (1948). The latter describes an unusual case in which Hodgkin's disease manifested itself by a sternal swelling of two weeks' duration. The following case is of interest in that a swelling had been present on the sternum for five years before the diagnosis of lymphadenoma was made, and because the patient had been successfully treated for pulmonary tuberculosis.

CASE HISTORY

The patient, a woman aged 36, with a considerable medical history, was notified to this department in July, 1947, as a case of tuberculosis, and was admitted on Aug. 11 to sanatorium for further investigation.

She had had measles and scarlet fever, injuries due to a fall of 30 ft. (9.14 m.) at the age of 13, and pulmonary tuberculosis at 22. She was in sanatorium from July, 1933, to January, 1934, and was treated by left A.P., which was continued privately thereafter; last refill January, 1946. Menstrual disorders for years; had D. and C. in 1943 and again in January, 1947. Chronic dermatitis of both hands.

A small swelling on the upper sternum first noticed about 1942 had remained static. After the uterine operation in January, 1947, the swelling had enlarged noticeably and progressively. In June, 1947, the condition was diagnosed as tuberculosis, and the case was notified to the public health department.

When I first saw her in July, 1947, her general condition was fair. She was febrile, toxic, and anaemic, but, apart from the swelling and some weakness, had no complaint. The lungs showed signs of fibrosis but none of any active disease. The cardiovascular, digestive, and nervous systems were clinically normal. The dermatitis of both hands was in a quiescent phase, but there was slight dry eczema of the webs of the fingers.

The swelling was a rounded painless protuberance on the upper sternum about the level of the second costal cartilages. It was exactly in the midline and occupied almost the breadth of the sternum. There was no tenderness or sign of pointing, but the overlying skin was reddened and fluctuation was present. No parasternal lymph nodes were detected. Aspiration was completely unsuccessful. Radiography of lungs and thorax revealed very slight old fibrosis in the right mid-zone, denser fibrosis in the left mid-zone with pleural thickening, but no sign of active disease or of hilar enlargement. The radiologist also reported a large round swelling of the soft tissues of the sternum both anteriorly and posteriorly about the second rib level; no erosion of the sternum was observed, but the anterior end of the second left rib was ill-defined. Other clinical findings were enlarged glands in both axillae but no adenopathy elsewhere; red cells, 3,730,000; Hb, 53%; white cells, 15,400; B.S.R., 51 mm./hour.

When she was admitted for sanatorium observation on Aug. 11 no definite diagnosis had been made. While various possibilities were recognized, tuberculosis was considered the most probable cause, especially in view of her previous history. On Sept. 4, however, biopsy of glands from the right axilla revealed changes typical of lymphadenoma. The patient was thereafter transferred to a general hospital where she received deep x-ray therapy, and was discharged on Nov. 21. Since then she has gone to live in the country and has not been examined, but is known to be fairly well (November, 1948).

I have to thank Dr. S. I. A. Laidlaw, Medical Officer of Health, Glasgow, for permission to publish this case.

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