of the liver, and Glenard himself showed the importance of the hepatic element in such conditions. Insulin treatment, combined with glucose feeding, also constitutes an important element in the treatment of such patients, but is not successful with all of them. It is better applied in a nursing home. Crenotherapy must be applied to such patients when their condition is not far advanced. The Vichy type of spa is essentially indicated, because it acts as Glenard has shown, through the modification of the functions of the liver. Carlsbad and Chatel-Guyon are indicated in forms with distinct constipation; Harrogate, Bridge-of-Allan Spa, Cheltenham Spa, Leamington Spa, Vittel, Kissingen, and Wiesbaden for a milder treatment.

Surgery must be considered only as an adjuvant method, and is indicated exclusively, in my opinion, when the duodenum is involved. Even in this case everything must be done to treat the patient medically before there is any surgical intervention, and also to continue internistic treatment after surgical operation. I have seen so many patients, after a more or less short temporary relief following operation, relapse into their previous condition, that I am becoming more and more sceptical about the success of these procedures. I am asking myself if that temporary relief has not been determined by the enforced rest and severe treatment in a nursing home necessitated by the operation. Such nursing home treatment, incidentally, is much indicated in these cases.

GASTRO-ENTEROPTOSIS WITH PERIVISCERITIS

This is the fourth form of gastro-enteroptosis, and differs from a clinical, physiopathological, and therapeutical point of view from the others. Clinically it is characterized principally by the fact that pains are more intense, more permanent, and are not relieved in the horizontal position, nor by Glenard's test. Digestive disturbances, gastric or intestinal, are also more marked, more permanent, and also persist in the horizontal position or in the eliciting of the Glenard's test. The general impairment of nutrition is great. Pain is elicited on pressure in various parts of the abdomen, and radiological exploration shows the immobilization of the viscera. These patients are organic gastro-enteroptotics in whom perivisceritis has determined adhesions. This perivisceritis is most frequently the effect of abdominal operations. The soil is very important, and it has been noted that there are individuals in whom post-operative adhesions are produced more easily than others. Perivisceritis may, however, be the sequel of a simple colitis.

Treatment differs from that of the other forms. The basic therapeutical method is abdominal diathermy, which—as all the physical methods relating to digestive diseases—must be applied under the direct supervision of the gastro-enterologist. The diathermy is helped in its action by certain protein shock preparations. Visceral orthopaedy in this form does more harm than good, and patients feel very uncomfortable with abdominal belts. Massage is contraindicated. Surgical intervention may bring a temporary relief, but it is well known that adhesions separated surgically are easily reformed. Care must be taken to prescribe for these patients a diet as complete from a qualitative and quantitative point of view as possible. Psychotherapy is important, but is not the predominant method, as in the case of neurotic gastro-enteroptosis. Treatment in a nursing home is strongly advisable. Crenotherapeutical procedures are useless.

GENERAL CONCLUSIONS

Enough has been said to show that within the frame of the textbook gastro-enteroptosis, modern clinical observation—the basis of the science of treatment—allows

us to distinguish four essentially different conditions, each one susceptible to different therapeutic procedures. The constitutional gastro-enteroptosis, or Stiller's syndrome, is a constitutional type and not a disease. The neurotic gastro-enteroptosis, or Adler's syndrome, is a nervous disease. Glenard's syndrome, and the gastro-enteroptosis with perivisceritis, are both organic diseases.

This division is, of course, important only from a nosographical point of view; we treat individuals and not diseases. In order to treat individuals, however, and to be able to detect the individual peculiarities of each patient, precise clinical descriptions of groups are necessary, and the justification of the description I have given is that it serves as a better introduction to individual treatment than does the usual textbook conception.

A NOTE ON FOOD ALLERGY

BY

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Hypersensitiveness to the proteins of certain kinds of food is more common than is generally realized, and may show itself by various forms of reaction. The appearance of an urticarial rash, and occasionally vomiting and diarrhoea, in some people, following the ingestion of shell-fish (for example, oysters) has been recognized for a long time. But proteins from many other foods may produce allergic reactions in susceptible individuals, and, moreover, it would appear that the exciting agent need not necessarily be a protein, but that non-nitrogenous substances may possibly be responsible in some cases.

SYMPTOMATOLOGY OF FOOD ALLERGY

Acute Cases.—Symptoms may be gastric or intestinal, or both, and come on promptly after eating the particular food to which the patient is sensitive. In many cases sickness and vomiting, abdominal pain, colic, distension, constipation, and sometimes diarrhoea, are the most frequent symptoms. They are probably due to spasm of the smooth muscle with congestion and oedema of the mucous membrane and resulting hypersecretion. Some of the severe cases may simulate an acute surgical abdomen, and symptoms of obstruction—due to muscular spasm and localized angioneurotic oedema—may lead to an unnecessary laparotomy being performed.

In other cases the colon reacts and a mucous colitis occurs. An attack of urticaria or angioneurotic oedema may accompany the gastro-intestinal disturbances, but this is by no means a constant feature. An acute oedematous swelling of the lips, mouth, and pharynx, associated with a burning sensation in the mucous membranes, occasionally arises, and may be accompanied by mucous colitis. Urticaria and angioneurotic oedema may occur independently of other manifestations, and may affect any part of the body. Sometimes an attack of migraine or other cerebral disturbance is set up; at others there may be an attack of dyspnoea or bronchial asthma. In a few instances, fortunately very rare, alarmingly grave symptoms resembling acute anaphylactic shock appear at once. Here there is severe abdominal pain accompanied by sickness, vomiting, and diarrhoea—sometimes bloody—urticarial rash, collapse, and even death within a few hours.

Subacute and Chronic Cases.—Among symptoms met with are abdominal discomfort or pain of varying degree, a feeling of sickness, and sometimes vomiting. They may

simulate those of chronic gastric or duodenal ulcer, chronic appendicitis, or cholecystitis. Pain in the lower abdomen accompanied by painful micturition may simulate bladder trouble, and rectal spasm and tenesmus may suggest a local lesion, or possibly a tabetic crisis. Symptoms of mucous colitis are frequently the chief feature of chronic cases, and hyperperistalsis with diarrhoea or constipation may be present. The symptoms generally persist over a long period unless the nature of the condition be recognized and dealt with accordingly.

In acute cases the close and constant relationship between the symptoms and the ingestion of a particular food is frequently discovered by the patient himself, and he knows that unless he avoids this food he will be ill. In subacute and chronic cases, however, the symptoms are more insidious, and while they always bear a relationship to food this may not be so obvious, as the interval may be longer than that in the acute cases and the symptoms may vary in severity. Further, symptoms often simulate those of other subacute or chronic abdominal conditions.

Eczema in young children is not uncommonly allergic and due to sensitization to food such as egg, cow's milk, oats, wheat, barley (barley water). The allergic agent may even be conveyed to the infant from the mother's food through her milk. Cases of infants being seriously ill at weaning time,^{1 2} when given their first feeds of cow's milk, are also known, and the symptoms recorded have included pallor, redness and oedema of lips, severe asthma, and violent vomiting. The severe symptoms pass off in an hour or two, leaving the child prostrated, and on the following day it is quite well until the next feed is given.

INFLUENCE OF HEREDITY

There is much to be said for a hereditary factor in allergic disease. It is often familial in distribution, and allergic manifestations of one form or another tend to be prevalent among closely related persons. The specific sensitivity is possibly not inherited, but the ability to become sensitive is transmitted from one generation to another, and anyone with such an inheritance may become sensitive to any allergic agent with which he may come into adequate contact. Thus it does not necessarily follow that descendants will suffer from the same type of allergic manifestation as their antecedents.

The following case is a good example of chronic food allergy in which the patient was sensitive to eggs:

A healthy man, at the age of 35 years, had an attack of abdominal pain which confined him to bed for a week and was considered to be due to appendicitis. Four months later he had a similar attack, and this time his appendix was removed. Eight months after the appendectomy he began to suffer from vague abdominal pain, sometimes fairly severe, and generally more marked in the epigastrium. Lasting about half an hour, or perhaps an hour, the discomfort or pain generally came on about two hours after breakfast, or in the evening two hours after the main meal of the day, but seldom after the light midday lunch. He would suffer in this way for several days, and then perhaps for a week or more he would feel quite well. He never vomited and never had any melaena. From the onset of the symptoms he dieted himself, taking no meat, vegetables, or fruit, but restricting himself to milk foods, eggs, tea, and bread-and-butter. He found, however, that such dietary made no difference to his symptoms, and, after about seven months' suffering, he came under my care as a possible case of gastric or duodenal ulcer. He was found to be a well-nourished and healthy-looking man, whose bowels moved regularly without aperients, and whose only complaint on examination was some general abdominal pain and more marked local pain and tenderness in the epigastrium (at the upper end of the old operation scar). Nothing abnormal could be made out in any of the systems. Fractional gastric analysis and x-ray examination of the gastrointestinal tract revealed no abnormality, and the Wassermann reaction of the blood was negative.

Pending investigations he was put on a milk diet (including eggs), but, as the symptoms were in no way relieved at the end of five days, he was given some tinct. belladonnae before meals and an alkali powder after. The pain and discomfort got worse, however, and three days later the belladonna and alkali were stopped and he was given a dietary of fish, bread-and-butter, and tea. The milk foods and eggs were continued, but in smaller quantities, for two days more. As there was no improvement in his symptoms the possibility of an idiosyncrasy was thought of, and it was decided to omit the eggs from the dietary. Immediately this was done the pain and discomfort disappeared and the patient felt better. Six days later he was given the ordinary hospital light diet, but *without eggs*, and allowed out of bed. Symptoms did not recur. He was sent home with instructions to eat all ordinary foods, but scrupulously to avoid eggs and any puddings, cakes, etc., containing eggs. He has since remained perfectly well and, taking care to avoid eggs in any shape or form, he can eat everything else, including roast pork.

On inquiring into his history it was found that he had previously enjoyed good health, although he had been subject to nasal and bronchial catarrh, but not to hay fever or asthma. His father, who was still alive at the age of 79, had suffered from asthma since he was 70. His maternal grandmother had suffered from asthma, and his only child was also an asthmatic.

DIAGNOSIS AND TREATMENT

In the diagnosis of a case of food allergy the history is of the greatest importance. Careful inquiry into each attack is essential, and all varieties of food taken at every meal must be reviewed and their relation to attacks or the absence of attacks noted. A previous history in the patient or his family and antecedents of asthma, hay fever, urticaria, angioneurotic oedema, migraine, eczema, or even gastro-intestinal symptoms, is suggestive. Sometimes the patient himself will suspect certain foods which seem to disagree with him, or he may have definite dislikes in regard to certain articles.

In those cases the effect of the elimination of such foods from the diet should be tried. It is often necessary to get the patient to keep, for a time, a diary of all the articles of food he eats and to note the occurrence or exacerbation of symptoms. It may then appear that symptoms are always present on the day when some particular kind or combination of food has been taken or on the following day. Another method, recommended by Rowe,³ is to draw up a series of trial diets (Rowe suggests five), each differing from the other as far as possible and containing foods which only rarely produce allergic effects. Each diet is tried in turn for one to two weeks until one is found which does not produce symptoms. This is then used as a basic diet, and to it new foods are added every three or four days, beginning with those least likely to produce allergy. Any food that gives rise to symptoms is then permanently excluded, and eventually the patient will know exactly what foods he must avoid.

Rowe has found that the foods most frequently giving rise to allergic reactions are wheat, eggs, and milk. Next in frequency come chocolate, cabbage, tomatoes, oranges, potatoes, cauliflower, strawberries, bananas, walnuts, carrots, and pork. Among those least likely to cause trouble are poultry, turnips, peas, beans, prunes, honey, beetroot, radishes, asparagus, mushrooms, plums, pepper, vinegar, and tea. Intermediate in frequency are salmon, oysters, lobsters, crabs, shrimps, rice, lettuce, celery, peaches, grapes, cherries, raisins, figs, lemons, almonds, beef, lamb, mustard, and coffee. There are many others.

If the patient is not sensitive to milk then a basic diet of milk only may be used and other foods added from time to time, the effect of each addition being watched. In some cases minute quantities of a food may be sufficient to produce symptoms, hence the necessity of identifying all the constituents of any article of food. Sometimes

a patient may be very mildly sensitive to more foods than one, and a combination of them will produce symptoms, whereas one alone is insufficient for any appreciable effect to result. I have seen a patient who would develop severe symptoms—abdominal pain, sickness, and vomiting—following the ingestion of coffee and cheese at one meal, whilst he could take either of these at separate meals without effect.

Skin tests similar to those with pollens in hay fever have been tried in the recognition of allergic foods, but they are by no means infallible. At present a careful history, a scrutiny of the diet, and the use of trial diets constitute the principle lines to be followed in the recognition of the offending food.

Treatment resolves itself mainly into careful exclusion of the particular food responsible for the symptoms. In some cases prolonged exclusion of the food from the dietary results in desensitization, and the patient eventually can resume taking the food, beginning with small quantities. This is always worth trying. I can recall one young man who as a boy suffered severely from recurring attacks of sickness, vomiting, and diarrhoea for about three years; it was then discovered that the attacks always followed the ingestion of fish. On excluding fish from his diet the attacks ceased. After an interval of four years he started taking fish again, and has had no recurrence of the trouble. It is interesting to note that

his father suffered from the same form of allergy to fish. With the important foods, such as milk and eggs, an attempt may be made to desensitize the patient by feeding with slowly increasing quantities—beginning with minute traces of the diluted article—over a period of several months. Less important foods may be simply omitted without further ado. Adrenaline often relieves the urticaria, angioneurotic oedema, serum rash, and asthma of allergy. Five to ten minims of the 1 in 1,000 adrenaline chloride solution may be given hypodermically or intramuscularly at once, and repeated every three or four hours if necessary. Another method is to give two or three minims hypodermically at half-hourly intervals. Sometimes the other allergic manifestations may be relieved by full doses of adrenaline, hypodermically or intramuscularly, and in some cases this may relieve the pain better than morphine.

Needless to say, in the diagnosis of food allergy other pathological conditions must be ruled out, and this may entail laboratory and radiological examinations and a detailed investigation of the case from all aspects. The possible coexistence of food allergy and some other pathological lesion must also be kept in mind.

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NOMENCLATURE AND FUNCTIONAL NERVOUS DISORDER

BY

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The progress of any branch of science is largely dependent upon the possession of a sound nomenclature and terminology. Scientific terminology should ideally be such as to convey the meaning, or as much of it as possible, by the terms used, or, where that is not possible, should be descriptive. An example of the first kind is unfortunately all too rare, but is approached, at least, by such a term as "appendicitis"; here the name conveys in itself the information that the condition is an inflammatory condition of the appendix. The second class of term is that which is a purely arbitrary word symbol, in itself conveying nothing and acquiring significance by convention only—for example, "influenza" and "rheumatism." Here the name is comparable with an empty vessel which we fill with meaning. The third and worst class of term is that which expresses something other than we wish to convey, and is therefore definitely misleading. It is like a vessel which is already filled with something that we do not require, and which has to be emptied before it can be replenished with that which is needed. The risk that its final contents will be somewhat mixed is obvious.

Nearly all the terminology relating to so-called "functional nervous disorder" falls into this undesirable third category. The result at the present moment is chaotic. Imagine a young medical student asking this very pertinent question: Is the relation between a nephritis and a nephrosis the same sort of thing as the relation between a neuritis and a neurosis, and, if not, what is neurosis, and why is it so called? How many people could answer clearly and succinctly?

It is now generally accepted that all so-called functional nervous disorder is the outward and visible manifestation of an inward and invisible conflict taking place within

the personality of the individual, and represents an unsatisfactory adjustment, a maladjustment, to life on the part of the individual. We know so little about psychological processes that we do not at present possess any words to describe exactly what is taking place in the "conflict," nor, indeed, have we any clear-cut concept of the matter. We can only grope in what might be termed "the twilight of the mind" towards a half-conceived "idea," used in the Aristotelean sense of the word. In the words of the poet:

"I would seek until I found
Something I can never find,
Something lying on the ground,
On the bottom of my mind."

This much, however, appears to be emerging from the mists—namely, that the disorder produced is a disorder of the effective aspect of mind, and that changes of affect are transmitted and translated throughout the human organism as what we call emotion, or feeling tone, or even more popularly "feelings."

As man advanced in the course of evolution, but long before he became possessed of a thinking mind and intellect, his reactions to stimuli were determined by the affect which such stimuli set up. The nociceptive stimulus (that which was dangerous to the organism) set up a negative—that is to say, a definitely unpleasant feeling tone or affect. The vegetative nervous system (sympathetic and parasympathetic), in association with the hormonal and other regulative chemical factors, which together form the vegetative neurochemical system, have ever been the handmaidens of "affect," and their reactions are immediately modified by any change in this realm. Thus all variations of affect set up incalculable changes in the whole organism, and profoundly and instantaneously vary the neurochemical balance, which presides over all the "vital" processes. The importance of this mechanism for the preservation of the individual is obvious. If it had not acted with great efficiency in past ages man would not have long enough survived the rigours of his environment to develop the higher mental faculties of judgement and reason.

These higher mental faculties under ordinary conditions not only have no place in the regulation of the vegetative