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

processes of the organism, but are a potential danger to it. They are adapted to deal with situations which present a choice of action, whereas the integrity of the essential vital processes absolutely requires a stereotyped response. The higher mental processes usually "keep their place," and only exercise a watching brief over the lower centres, ready to step in and exert a controlling influence if necessity arises. In the same way "affect" usually keeps its place—which is that of foreman of the neurochemical vegetative system—with a good deal of influence over the higher centres, but normally under their control.

What occurs when a conflict arises within the personality? Obviously all this excellent organization and interplay of control is to some extent thrown out of balance. "Affect," instead of being in a state of what might be termed "neutral equilibrium," either swings wildly from pole to pole or, if the condition persists, takes up a new equilibrium less favourable to the organism as a whole. For it must be always borne in mind that the vegetative neurochemical mechanism regulating all the essential vital processes faithfully follows every deflection of "affect," as the waves follow the moon.

We may more easily arrive at some conception of what is occurring in these conditions now spoken of as nervous breakdown, neuroses, psychoneuroses, and neurasthenia, by using the analogy of music. The normal key of C major may be compared with the normal reaction pattern of the human organism, a stable and yet labile emotionally neutral condition. Any stimulus producing a highly charged feeling tone or "affect" has already been described as setting up great disturbances in the more primitive neurochemical levels of the organism, which are under the direct influence of "affect." Such a disturbance may be compared with the introduction of accidentals into the scale. When the need for them has passed, the normal scale is at once restored. Imagine, however, that owing to prolonged or profound stimuli influencing the feeling tone or affect the whole reactions of the organism are transposed into a different key, one which is less favourable to the organism than the normal C major. It is easy to appreciate the fact that a state of tension soon results which is ultimately going to lead to exhaustion or, in extreme cases, to the break-up of the integrity of the organism as a whole. We already use this musical analogy in everyday speech to describe such a state of emotional stress when we say that we feel "keyed-up" or "strung up to concert pitch." Our feeling tone or affect may be considered as the factor which determines the "key," and so sets the pattern for our whole emotional reaction.

The key that is usually set in these conditions is one of anxiety, since the underlying cause is a conflict. This will readily suggest "sharps." As the anxiety state gets more and more acute the key changes into more and more sharps until we reach the limit—seven sharps. Now we are at the trope or turning point. What is on the other side? The key of seven flats; in other words, an exhaustion state. The organism is giving up the struggle, it cannot cope with the situation any more on those lines, and what is commonly termed "neurasthenia" may supervene.

In some cases exhaustion states seem to occur without the intermediate anxiety state, or after only a very brief period of anxiety, especially in people of poor physique and deficient vitality, which is very much what one would expect. In extreme cases, in which the emotional system is very unstable or unadjustable, a complete dissociation of the personality may arise. The situation cannot be brought into assimilation with the individual's personality, and so a separate stream of consciousness arises and flows alongside of the main stream, or, it may be, disintegrates its channel. When this occurs we are dealing with estab-

lished mental breakdown, some form of what is commonly termed "insanity," in which the throne of reason is threatened or overturned.

Such states, however, do not commonly follow on the so-called neuroses, but seem usually to appear *de novo*; though it is probable that a prolonged conflict within the personality has been occurring without showing symptoms that have been recognized as such either by the sufferer or by those around him.

It would seem that some types of individual tend towards obtaining an adjustment of their psychological difficulties within the normal confines of the personality, and that others tend to a splitting-off or splitting-up of the personality. Such an hypothesis may explain those cases termed "borderline," which are neither quite sane nor quite insane, and some of which appear to show from time to time evidences of a typical anxiety state.

This brief summary illustrates how inaccurate, and indeed acutely misleading, are all these terms beginning with "neu-" which have been pressed into a service they were never meant to perform. They are based on an entire misconception, and now that we no longer have that misconception it is absolutely undesirable, and even indefensible, to continue using a wrong terminology.

With what terminology shall we replace the discarded one, since a terminology we assuredly must have? There is no word in any language which exactly conveys that which is connoted by the word "affect" used in the special sense in which it is employed here and in modern psychology generally. But to name those states where there is a marked and recurrent swing of the emotional pendulum, with the transient or more or less persistent establishment of an emotional equilibrium that is either above or below the individual norm, the Greek word "thyme" was introduced. Because they are recurrent, and possibly also with a view to expressing their polarity, the term "cyclothymia" was coined. Although "thymè" does not quite correspond either with affect or with emotion, it is sufficiently near to them to convey something of the underlying meaning, and has the added merit that to the modern world it does not suggest anything else.

Everyone resents having to learn new words for old, but it would seem both logical and necessary to invent a word for these states of conflict and maladjustment with their protean physical and mental concomitants, at present wrongly spoken of as neuroses, psychoneuroses, neurasthenia, and nervous breakdown. These terms, in so far as they have any scientific meaning, mean something quite other than the truth, and in popular parlance are regarded as a euphemism for insanity on the one hand and malingering on the other.

The word which appears the best adapted to fulfil the role of a generic term for all so-called functional nervous disorders is "dysthymia," composed of the Greek prefix "dys"—widely used to connote disordered functioning, as in dyspituitarism, dysmenorrhoea—and the Greek word "thyme," already accepted as a synonym for affect and emotion. It has the added merits of brevity and euphony.

Armed with this word the position of the doctor in relation to both patients and relatives is immeasurably strengthened and simplified.

Who has not suffered from the lack of the *mot juste* when asked by a patient suffering from a form of dysthymia—an anxiety state, for example, manifesting itself by such symptoms as sleeplessness, fatigability, impaired concentration, sensations of pressure on the top of the head, dyspepsia, or even "functional" paralyses, and anorexia—"What really is the matter with me, Doctor"? It is even worse when we are pinned down to a diagnosis by the relatives. Any of the terms now in

use have obvious disadvantages in that they are all suspect by the laity, and however we may insist that the patient is neither malingering nor "mental," nothing will ever quite eradicate that belief from the minds of both patient and relatives. Furthermore, *horresco referens*, they convey a similar implication to not a few of the medical profession.

Even psychiatrists themselves are not agreed as to the exact connotation of the terms they use, and therefore often find themselves at cross-purposes. On the day when all the "neus" are unreservedly and irrevocably handed over to the neurologist, psychopathology and psychiatry will have made a forward step of incalculable importance.

Memoranda

MEDICAL, SURGICAL, OBSTETRICAL

TWO RARE TYPES OF HERNIA OCCURRING IN THE SAME PATIENT

A hernia of the linea semilunaris is in itself a distinctly rare occurrence; an umbilical hernia containing nothing but the dilated distal portion of a complete Meckel's diverticulum is rarer still. The following case, recently under my care in the surgical unit at St. Mary's Hospital, in which both conditions were present, in addition to a large omental hernia in the scrotum, must be almost unique.

A man of 42 was admitted to hospital on January 14th, 1932, for a strangulated hernia of the right linea semilunaris.

History.—Eight years ago the patient started work which entailed lifting heavy baskets of linen and carrying them on his shoulder. Within a few months he developed a right inguinal hernia, for which he was ordered a truss. Shortly after this a small hernia developed at the umbilicus, and then a third hernia at the right linea semilunaris, immediately below the costal margin (pararectal). The pararectal hernia increased to the size of a hen's egg, but gave rise to no symptoms. On the evening before admission the patient slipped while at work, and to save himself from falling caught hold of an overhead bar, violently contracting his abdominal muscles. The pararectal hernia immediately swelled and became painful. Next morning the patient had an attack of vomiting.

On admission his general condition was good, although suffering from slight shock. There was a large scrotal hernia on the right side, and an umbilical hernia, both giving an impulse on coughing. The skin over the umbilical hernia was intact. There was a large swelling, the shape and size of a human kidney, over the right costal margin and lower ribs; this was tense and tender, had a slight impulse, and was irreducible.

Operation (two hours after admission, under general anaesthesia).—A six-inch incision was made, parallel to the sub-costal margin and over the hernia. The sac was identified and opened. It contained a large quantity of blood-stained fluid and a strangulated loop of small intestine about six inches in length. The intestine was very congested, but recovered its colour after the constriction of the neck of the sac had been stretched. More intestine was pulled out and inspected, and it was decided that the gut was viable and could be returned. The neck of the sac was dissected clean, transfixed, and ligatured, and the sac excised. The hole in the abdominal wall was three-quarters of an inch in diameter, and was situated exactly where the right linea semilunaris meets the costal margin. This was repaired by overlapping and suturing.

Second Operation (January 29th).—(1) For inguinal hernia: a radical cure performed; the sac contained a very large piece of omentum, but no intestine. (2) For umbilical hernia: a two-inch transverse oval incision was made, circumventing the hernia and umbilicus; the neck of the sac was identified, cleaned, and opened. The hernia contained the distal third

or more of a complete Meckel's diverticulum. The diverticulum was six and a half inches long, and was completely canalized. Its proximal end opened into the ileum more than a foot from the ileo-caecal junction; from here it stretched as a cord to the umbilicus, while the distal third of it was convoluted, and was dilated to three or four times the diameter of the proximal part. This distal and dilated portion was lying coiled up in the sac of the umbilical hernia, which contained nothing else. The blind end of the diverticulum was adherent to the sac. There was no stricture of the ileum. The proximal end of the diverticulum was surrounded by a purse-string suture, crushed, and ligatured. The stump was pushed into the ileum and buried by tying the purse-string, while the diverticulum and sac were removed in one piece. The Mayo technique resulted in a radical cure. The patient made an uninterrupted recovery, and left hospital on February 14th.

Comments

1. It is interesting to observe that all three herniae appeared within a year of the patient taking up heavy work.

2. The situation of the swelling of the subcostal hernia, and the way in which the distended sac overlapped the costal margin and lay largely on the chest wall, might have obscured the diagnosis had not the patient insisted that before its recent and sudden enlargement the swelling was entirely below the ribs.

3. The Meckel's diverticulum was canalized from its intestinal end to its distal blind end. Its attachment to the parietes, represented by the anterior wall of the hernial sac, is of obvious embryological significance. The distension of the distal third, lying in the umbilical hernial sac, was of the nature of an open mucocele.

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MENINGO-ENCEPHALITIS OF MEASLES

Meningo-encephalitis of measles is a rare complication. In a summary of the literature, Ford¹ describes only 113 reported cases and adds another twelve, of which eight occurred in a series of 55,000 cases of measles.

Case Record

B. C., aged 23, a healthy youth, showed a typical early rash on March 9th, 1932. In the following two days the rash developed into a very severe one, but the patient was not unduly ill. On March 12th he surprised the rest of his family at lunch by suddenly appearing in a half-clad condition. His speech was rambling, and he signaled his arrival by an almost immediate convulsion. He was carried back to his bed; returning consciousness found him restless and extremely irritable. He vomited once, and complained of headache. Next day he was violent at times, incoherent in his speech, resented any form of interference, and lapsed for periods into semi-stupor. Physical examination showed no localizing signs in his central nervous system. Kernig's sign was negative, neck rigidity indefinite, and the ears showed no evidence of disease. Temperature 101.4°, pulse 84, respirations 24. A few scattered rales were present in his chest, and he had a considerable difficulty in micturition. On March 14th he was already more rational; temperature 100.4°, pulse 80. Lumbar puncture was performed, the cerebro-spinal fluid being under obvious increase of pressure.

A pathological report of the cerebro-spinal fluid gave the following findings: Faintly opalescent fluid—no clot. Leucocytes, 224 per c.mm.; lymphocytes, 96 per cent.; red blood cells, 64 per c.mm.; proteins, 70 mg. per cent.; globulin (Nonne-Apelt), positive (+); chlorides, 720 mg. per cent. No organisms seen. Culture, negative.

On the following day the patient was mentally normal; temperature 97.8°, pulse 76. He appears to have completely recovered, and at no time has had any localizing sign in his central nervous system.