In the more severe type of non-responsive case, an even more elaborate form of vaccine treatment may be required as a preliminary measure—namely, the employment of a donor to provide an autogenous immune serum. A whole-blood immune transfusion may be used as an alternative in specially debilitated cases with good immediate, though temporary, results, and may be followed up by the sensitized vaccine similarly obtained.

The other and commoner group of non-reactive and non-responsive cases does not show these grave signs of debility, but is apparently impervious to any effect whatever of ordinary full doses of vaccine. Such a condition is often found in cases with marked furunculosis and other conditions of local infection, less frequently in chronic catarrhal and rheumatic conditions. The usual vaccine doses are inadequate, and will be written down as a failure unless doses of much greater amount than usual are employed. For instance, in certain cases of furunculosis which have been abandoned as failures, completely satisfactory results have been obtained when the dosage has been increased to three or four times the usual maximum amount.

INSUFFICIENT DURATION OF TREATMENT

This is a further cause of failure, and applies especially to the chronic type of infections. It is irrational to expect a few small doses of vaccine, however carefully they are prepared and arranged for, to arrest an infective process that has been present in the system for months or years, and much less to reduce or replace pathological processes which have been established. Good results are usually obtained by persistent, careful treatment. But vaccine therapy is not a simple and easy matter. It frequently demands much patience and thought, and gives scope for considerable nicety in the successful management of a difficult case. Without such care, failures are more often due to the lack of proper administration than to any fault in the vaccine or therapy itself.

Although many may do well after a single course of ten to twelve inoculations, most cases of chronic infection, such as the rheumatic group, will require many more, and it is quite usual to have to continue a systematic treatment with vaccine for at least a year. Nor should it be considered extravagant to suggest that in the severe cases treatment may have to be carried on, perhaps with intervals, for two or even three years before ultimate success is obtained, when it is considered how extensive the tissue damage may be, how long the infection has been present, and how debilitated the patient's general condition has become. If vaccine treatment in cases of rheumatic infection, for instance, was commenced earlier and persisted with efficiently, a large percentage of the permanent disabilities from this cause would be prevented.

The first aim of vaccine therapy is to arrest the infective process by raising an efficient bacterial resistance. When this has been accomplished, further treatment must still be directed to the maintenance of an active immunity and to the recovery, so far as is possible, of pathological tissues. These later courses of vaccine will usually allow of a considerable increase of interval between doses, which are themselves only increased in amount when further improvement is absent. In some cases the natural power of maintaining an adequate resistance to a particular infection appears to be deficient, and in such the best method of maintaining their freedom from reinfection is by the persistent continuation of vaccine treatment at, perhaps, monthly intervals. Numerous sufferers from chronic respiratory, intestinal, and rheumatic infection have been changed from a life of invalidism to comparative normal activity by the employment of this method of continuous vaccine treatment, which, if omitted for too long an interval, results in the gradual reappearance of some well-recognized symptoms of relapse.

IRRATIONAL EXPECTATIONS FROM RESULTS

This is the last cause of failure to be mentioned. Too much in certain cases is expected of a mode of treatment, the action of which must necessarily have definite limitations. Vaccine therapy is not in any sense a "cure-all," and even if there are conditions in which it may be more or less successfully employed as a non-specific agent in protein shock therapy its essential sphere is that of a specific immunizing agent against specific infections.

If a presumed infective condition proves, on investigation, to be one of metabolic derangement, and the infector is only one of secondary although perhaps contributory importance, vaccine treatment of this must not be blamed if failure to correct the primary non-infective condition results. In most chronic infections it is at times more important to treat the associated and resultant derangements of tissue metabolism than to concentrate solely upon the infection itself, and, unless vaccine treatment is combined with other remedial measures, it cannot be expected to produce the result or improvement which is anticipated clinically. Vaccine treatment is an invaluable therapeutic measure, and all too frequently advantage is not taken of its help in the scope of clinical practice. It is either not employed early enough to be of real service, or too much is expected of its exhibition under conditions which preclude its success.

There are, therefore, several causes of failure in vaccine treatment, some of which may be avoided by a proper appreciation of the underlying difficulties which are apt to exist, others which depend upon the presence of pathological conditions beyond the scope of clinical control. Nevertheless, when all details are considered, failures occur in not more than 20 per cent. of cases, and, as pointed out above, may with proper care be definitely less.

REFERENCES

- ¹ Jenkins: *British Medical Journal*, March, 1928.
- ² Crowe, Warren: *Treatment of Chronic Arthritis*.
- ³ Solis-Cohen, M.: *Journ. Exper. Path.*, 1927, viii, No. 3, 149.
- ⁴ Lowe, Cronin: *British Dental Journ.*, May 1st, 1928; *British Medical Journal*, July 21st, 1928; *ibid.*, July 13th, 1929.

THE MODERN TREATMENT OF GASTRO-ENTEROPTOSIS

BY

A. P. CAWADIAS, O.B.E., M.D. DURH. AND PARIS,
M.R.C.P. LOND.

LATE CHIEF OF MEDICAL CLINIC, PARIS UNIVERSITY, BEAUJON
HOSPITAL

Inefficacy in the treatment of gastro-enteroptosis is due to our erroneous conception of the unity of this morbid condition. Gastro-enteroptosis is not one disease. There are four distinct forms of it, and we could, in fact, from the nosographical point of view, speak of four different diseases. These are (a) the constitutional gastro-enteroptosis, or Stiller's syndrome; (b) the neurotic gastro-enteroptosis, or Adler's syndrome; (c) the organic gastro-enteroptosis, or Glenard's syndrome; and (d) the gastro-enteroptosis complicated by perivisceritis. For a perfect individualization of our therapeutic handling—the only safe way to success—we must consider this division, which is based, not on a static, but on a dynamic clinical observation of gastro-enteroptosis and also on the observation of the action of various therapeutical agents.

STILLER'S SYNDROME

The term "Stiller's syndrome" is applied to this form of gastro-enteroptosis because it was Stiller (of Budapest) who first pointed out the relation of gastro-enteroptosis to a type of constitution—that is, to a particular psychophysical construction of the individual.

This form of gastro-enteroptosis is not a morbid condition but a special type of constitution—one of those special "types" into which men have been grouped according to their morphological features. It coincides and is synonymous with what is known as asthenic constitution (Stiller and Kretchmer), linear type (Stockard), microsplanchnic hypovegetative constitution (Pende). Individuals who possess the features of this biotype have usually a stature below the average. Their thorax is bigger than the abdomen, and is narrow and long. The abdomen is restricted both in the transverse and in the antero-posterior diameter, and has flaccid and thin muscular walls. The limbs are long, the muscles thin, showing scarcely any outline. There is a very great scarcity of fat. Clinical and radiological examination of the internal organs shows a small and dropped heart, gastropptosis—meaning elongation of the stomach, which brings the inferior pole of this organ into the pelvis—coloptosis, and nephroptosis. These persons have a low blood pressure. Psychologically—as has been emphasized by the work of Kretchmer—they have a tendency towards introversion. They do not show any symptoms, and it is, in fact, remarkable how an intensely ptosed stomach may function perfectly. It must not be forgotten, however, that on account of their endocrine, vegetative and psychical inadequacies, they are predisposed to certain diseases; in other words, they resist certain external aetiological factors less well than do others. Thus defects of diet will produce in them various dyspeptic disturbances, infections will easily localize in the digestive tube, while psychical trauma will readily develop neurotic conditions of the introvert (schizoid type). Certain infections, like tuberculosis or scarlet fever, will develop more intensely than is the case with other people.

It is important to bear in mind the physiopathology of this condition. Such individuals are born with certain inadequacies of their endocrines and of their vegetative nervous system—vegetative imbalance and thyroid and gonad dysfunction. On account of this there occurs a maldevelopment of the stature, of the viscera, and also of the central nervous system, particularly of the psycho-associational cortex, the seat of the mental processes. The maldevelopment of the viscera consists in visceroptosis, which can be explained as follows. The stomach and the other abdominal viscera are maintained in position (a) by the tonus of the vegetative nervous system; (b) by the intra-abdominal fat, which constitutes a sort of cushion; (c) by the tonus of the muscular retention apparatus—diaphragm, abdominal muscles, and diaphragma pelvis. As in the individuals we are describing there occurs a constitutional disturbance of the vegetative nervous system and of the storage of fat, the production of this gastro-enteroptosis is easily understood.

From a therapeutic standpoint one may say regarding constitutional gastro-enteroptosis what Osler said of hypertension. The greatest complication of this form of gastro-enteroptosis is that a physician may discover it and communicate his discovery to the patient. Constitutional gastro-enteroptotics show no symptoms, and although the patients cannot lead a very strenuous life they can maintain perfect health up to a very old age. When, however, they are told by their physician that they have a dropped stomach the clinical picture changes completely. From that day onwards their life becomes terrible. Their attention being drawn to the dropped stomach, their mental balance—which as we have seen is not perfect—is upset. On the strength of their tendency to introversion they develop a syndrome of anxiety neurosis centred on their digestive functions. As, on account of their special mental make-up, they have the tendency to shirk the difficulties of life by the flight into disease—

in other words, to express their difficulties by what Adler has called organ jargon—a dyspeptic syndrome develops. Thanks to their physician, they have been furnished with a convenient form of organic expression of their difficulties. The first rule, therefore, in handling constitutional gastro-enteroptosis consists in the avoidance of drawing attention to the visceral condition, but this rule does not summarize the whole attitude of the internist. Something more positive must be done. The life of the patient must be adapted so as to make him avoid great physical and mental strain. His diet particularly must be adjusted so as to be of easy digestion, substantial quantitatively, and complete from a qualitative point of view.

ADLER'S SYNDROME

The term "Adler's syndrome" must be applied to this form of gastro-enteroptosis because it is owing to Adler that we understand the mechanism of the expression of the mental difficulties of an individual through symptoms related to an organ in a condition of inferiority, in other words, through organ jargon.

From a clinical, descriptive point of view sufferers from Adler's syndrome have the morphological features described with the preceding form—the gastro-enteroptotic habitus. They are not, however, free from symptoms, and even as children they give evidence of psychical imbalance, being nervous, sensitive and difficult. The real and complete morbid condition occurs later, and begins at certain periods of life corresponding to situations of mental difficulty as, for example, in puberty, marriage, menopause, or following great emotional stress. When the morbid condition is completed, symptoms may be grouped into two symptom-complexes—digestive and nervous—which are added to the morphological symptom-complex or gastro-enteroptotic habitus. Morphological, digestive and nervous symptom-complexes can thus be described as constituting the gastro-enteroptotic tripod. The digestive symptom-complex is of the irregular type. Patients complain of lack of appetite. They feel a great weight on the abdomen immediately after meals—even while they are taking their meals. Gas is expelled from the mouth following aerophagy, or from the anus. Intestinal symptoms such as constipation often occur. All these symptoms are not relieved in the reclining position, nor are they relieved through Glenard's test, to be described later. Their essential feature is that they are erratic. The nervous symptom-complex comprises headaches, insomnia, depression, a tendency towards brooding upon themselves (Kretchmer's schizoid syndrome) and, principally, anxiety as to their condition. These patients often think that they have a severe abdominal disease. They restrict their social activities. They restrict, in particular, their diet, and thus a vicious circle occurs, because the inanition to which they condemn themselves accentuates their gastro-enteroptosis. This inanition causes, in fact, the disappearance of the scanty intra-abdominal fat that remains, the atrophy of the muscular wall of the abdomen and of the viscera, and the dysfunction of the badly nourished endocrines and vegetative nervous system.

They thus differ clinically from those patients showing the pure Stiller's syndrome—a difference which can be explained by the study of their physiopathology. In this case also patients are born with the same psychical, endocrine, and nervous vegetative inadequacies which, in conjunction with certain external factors, help in the development of the constitutional gastro-enteroptosis of Stiller's syndrome. There is, however, a certain peculiarity in the aetiological constellation of Adler's syndrome in that the psychical constitutional inadequacy is more marked. Further, another mechanism interferes. Such

individuals remain for a certain time without any symptoms, as in the pure Stiller's syndrome, until they find themselves in a difficulty—in a position of psychical conflict. By the well-known psychical mechanism emphasized by Adler, this psychical conflict will express itself in organic language. To get out of his difficulty the patient grasps his inferior organ, the ptosed stomach, and concentrates his mind on it. He becomes aware of the slight disturbance of digestion due to gastro-enteroptosis, and he cultivates this disagreeable symptom as an escape from the conflict. A vicious circle is established, because the concentration of the mind on the stomach accentuates the disturbances of the organ. As I have already pointed out, this introduction of the psychical element into the gastropptosis is often initiated by the physician who speaks to the patient about a "dropped stomach."

Value of Psychotherapy

The physiopathology of this syndrome being different from that of Stiller's syndrome, treatment will also follow different lines. Psychotherapy is the basic, but not the exclusive, therapeutical procedure. The first thing that must be done is to find out the difficulty of the patient—his conflict—and endeavour to remove it. This does not demand those long psycho-analytical explorations which have been the fashion for a certain time. The careful study of the personality of the patient will be made while the physician is treating him with other methods. It is much safer not to concentrate on a pure psychotherapeutic handling, but to permeate with psychotherapy our whole procedure.

The next element of the psychotherapeutical handling of the neurotic gastro-enteroptotic patient consists in diverting attention from his digestive disturbances. This is a very delicate part of treatment, because such patients often hold fast to their morbid condition, as it is for them the means through which they satisfy their will to power. Thus we must endeavour to change the attitude of the patient to his disease. This will not be secured with rough optimism, the famous "pull yourself together" principle, but with a careful psychology, the success of which does not depend on this or that method, but on the tact and personality of the physician. While we are changing the attitude of the patient to his disease we have to encourage him, and of course this encouragement will be more easily accomplished through a distinct amelioration of the physical condition. Such patients are not purely mental. They have an organ inferiority of the stomach and intestines which must be dealt with. They have an abnormal condition of their vegetative nervous system and endocrines which also must be considered. Pure psychotherapy has never been a good method of treatment.

Other Forms of Treatment

Dietotherapy is also a star of first magnitude of the therapeutical constellation to be applied to these patients. Abundant, substantial, and easily digested food must be given, after taking into consideration the individual reactions. Many of these patients eat too little, not only because their digestive capacity is diminished, but also on account of a certain mental element of anxiety. This voluntary inanition accentuates, as we have seen, their morbid condition, by the mechanism of a vicious circle which must be broken through dietotherapy. As with all therapeutic methods, dietotherapy must not be applied exclusively, but in combination with other means of treatment. The high caloric and substantial diet which is advised in gastro-enteroptosis may not be supported without the help of certain pharmaceutical procedures. The patient will be advised at the beginning of the cure

to take his meals lying down, or at all events to rest on a couch during the digestive period.

Next to psychotherapy and dietotherapy it is a combination of physiotherapeutical procedures that is of the greatest importance in this type of patient. The best physiotherapeutical method in my experience is the continuous galvanic current—one electrode on the back, and another, slightly smaller, on the abdomen. Small doses, 10 to 20 milliamperes, are sufficient, but often patients cannot stand more than 5. A series of fourteen treatments, one every two or three days, brings great amelioration of the condition. Gymnastics, in the form of the various Swedish movements, respiratory exercises, and general massage, are of great help. The focusing of the attention on the gymnastics of the abdominal muscles is not here so important as it will be for the next form of gastro-enteroptosis. Climatotherapy is also valuable. A short sojourn in a mountain climatic station, or in the Highlands of Scotland, or at a height of over 3,000 feet on the Continent, is of great benefit. If, during this sojourn, a careful dietotherapy is applied, and the psychological environment is cultivated, a very beneficent physiotherapeutical synergy is obtained.

Further Methods

The therapeutical constellation will be completed by the following adjuvant methods: (a) actinotherapy under the form of carbon arc irradiation, with carbons rich in short ultra-violet; (b) pharmacotherapy in the form of alkalis; (c) biological therapy in the form of pancreatic or gonad preparations. Crenotherapeutical, orthopaedic, and surgical procedures are not indicated. It is useless to waste time with a sojourn at a spa when a stay in a climatic mountain health resort is far more beneficial. The wearing of an abdominal belt makes these patients feel uncomfortable, and rather helps them to cultivate their disease by concentrating their attention on their "dropped viscera."

As for surgery, it is when this procedure is applied to such a form of gastropptosis that the term "vandalism," used by Stiller, becomes adequate. In most cases patients suffer after the operation as much or even more than before. In exceptional cases some relief may be obtained, but I think that on these occasions we have to do with an intense form of psychotherapy. A few years ago I myself advised an operation in a case of visceroptosis which did not yield to any treatment, because I considered erroneously that the patient had organic gastro-enteroptosis. On opening the abdomen the surgeon found that the visceral condition was not such as to justify radical fixation, and he closed the abdomen without any special interference with the viscera. Notwithstanding that, the patient got rid of her symptoms.

Unfortunately many errors are committed in this direction because, by a singular coincidence, patients attacked with this affliction clamour loudly for active surgical intervention. When struck with what Texor calls the "mania operativa passiva" they may find themselves in the presence of surgeons afflicted with a "mania operativa activa," and the most fantastic operations may result from such an unlucky meeting.

GLENARD'S SYNDROME

The organic gastro-enteroptosis, or Glenard's syndrome—named thus from the Vichy clinician who first described gastro-enteroptosis in general and this form in particular—is not a pure constitutional type like Stiller's syndrome, nor a nervous disease like Adler's syndrome, but an organic disease of the digestive organs. In other words, although there is in such patients a constitutional and a psychical element, it is the local organic condition of the

digestive organs that dominates the clinical picture and directs the therapeutic handling.

Here also is found the same basic morphological symptom-complex, the gastro-enteroptotic habitus which characterizes the three forms of gastro-enteroptosis, but this morphological symptom-complex is more accentuated. Here also we meet with nervous and digestive symptoms, as in the neurotic gastro-enteroptoses, but they differ from those of the neurotic gastro-enteroptoses and depend on the anatomical condition of the organs involved. The common feature of these symptoms is the orthostatic accentuation. Symptoms are more intense when the patients pass from the horizontal to the vertical position, and, in general, rest in a horizontal position brings great relief. Symptoms are also relieved when Glenard's test is applied—that is, when the physician, placing himself behind the patient, makes a sort of belt with his arms, and tries either to raise with his two hands the hypogastrium or to press the whole abdominal surface from the front backwards. This relief through horizontal position and through Glenard's belt test is not met with in any other form of gastro-enteroptosis.

Features According to Localization

The anatomical condition of the digestive organs causes some variation in symptoms.

(a) In the total gastro-pyloro-duodenoptosis—that is, in cases in which the inferior pole of the stomach, pylorus, and duodenum are all lower than normal—the gastric evacuation is disturbed in general, and symptoms take the form of hyposthenic dyspepsia with aerophagy. Patients complain of weight in the stomach immediately after meals (and even while they are taking them), of flatulence, nausea, and constipation. The general condition is much impaired. There is a general feeling of depression and slight headaches. The pulse rate is usually accelerated, this acceleration also diminishing when the patient lies down (Leven's orthostatic tachycardia).

(b) In the vertical dislocation of the stomach its lower pole is ptosed, but the pylorus and the duodenal bulb remain fixed. There thus occurs a sort of obstruction in the pyloro-duodenal passage, and the clinical picture is that of the pyloric syndrome. At a certain interval after meals patients suffer from pains, acidity, and sometimes vomiting. These symptoms are grouped into periods of suffering—weeks or even months—and there are intervals of calm, as in the case of duodenal ulcer. Relief is marked in the horizontal position or during Glenard's test. The depression and the headaches are more accentuated.

(c) In gastro-pyloro-protoduodenoptosis the lower pole of the stomach, the pylorus, and the duodenal bulb are ptosed, but the second portion of the duodenum remains fixed. The pylorus and the protoduodenum drag downwards the second portion of the duodenum, and so make it describe a sort of horseshoe. The evacuation of this portion is thus disturbed, an occurrence which is accentuated by the closing of the duodeno-jejunal angle on account of that dragging down of the second portion of the duodenum. It is the disturbance of evacuation of the duodenum that explains the severity of the clinical picture, which takes the form of the duodenal stasis syndrome. Pains are late, as in the preceding group, and are accompanied by vomiting. An attack of diarrhoea often marks the end of the painful attack. There often occurs a slight jaundice, this hepatic involvement being due to the disturbance of the evacuation of the bile, from the abnormal position of the duodenum. The general condition is much disturbed, and the nervous symptoms are much more accentuated. It is in this form that we meet with the greatest cachexia, a condition which diminishes so much the resistance of the body that tuberculosis can

easily develop. It is here also that we meet with intense headaches, the so-called "duodenal migraines."

(d) In gastro-coloptosis the colon as well is ptosed, and in many cases the colon involvement predominates, being often limited to the right colon (mobile caecum). Intestinal symptoms, particularly constipation and attacks of diarrhoea, constitute the essential symptom-complex in the latter type.

The physiopathology of this condition explains these clinical peculiarities. Such patients are born with the same inadequacies of endocrines and nervous system as those belonging to the preceding forms. There is, however, a more localized maldevelopment of the viscera, and particularly anomalies of the development of the peritoneum. Later in life external aetiological factors act with greater intensity than in the case of the neurotic gastro-enteroptosis, and act particularly on the static condition of the viscera. These factors consist in faults in diet, in malnutrition, in various cachetic diseases, repeated pregnancies, and sudden diminution of intra-abdominal pressure, such as, for example, occurs in evacuation of ascites, or in removal of large abdominal tumours. Thus this localized constitutional maldevelopment of the viscera and this intense action of external aetiological factors on intra-abdominal conditions explain the preponderance of the organic visceral element.

Visceral Orthopaedy and Other Treatment

The preponderance of this visceral element indicates a line of treatment different from that of the preceding forms. The basic therapeutical procedure here is visceral orthopaedy. This consists in the application of various belts or bandages. Such belts are of two kinds: the Glenard type, which is a simple bandage, and the Enriquez type, which has a pneumatic cushion that can be filled with air. As far as possible, the first application of these belts must be made with the help of a radiological examination; at all events, the action of these belts must be followed closely for a time. Often patients feel a great relief, but in certain cases this does not occur, and there may even be an accentuation of the symptoms. This means either that the suspension of the viscera has not been well made, and on this point an x-ray examination will give certain information, or that there is a superadded nervous vegetative disturbance, in which case the belt must be discarded.

Visceral orthopaedy will be completed by a combination of special electrotherapeutical and kinesi-therapeutical procedures, consisting of massage of the abdominal muscles, special gymnastics of the abdominal muscles, aided by the application to the latter of galvanic interrupted current. This form of physical treatment cannot, however, yield any results unless it is applied by the gastro-enterologist himself. As we have seen, conditions in gastro-enteroptosis are so complicated that an unqualified masseur, or a simple technician electrotherapeutist, can do more harm than good. The evolution of gastro-enterology towards the application of physical methods by the specialist himself finds, in such cases, an ample justification.

Dietetic treatment cannot follow, in this form, the lines indicated for the two preceding forms, because there is a great incapacity of the digestive function. We must, however, try to give patients substantial feeding, following the individual reactions of each individual case, and help the digestion with various pharmaceutical preparations. Among these the best are alkalis, in small doses taken immediately after meals, mixed with sodium sulphate (half a drachm of each in a tumblerful of Vichy water taken in the morning on awakening). This last preparation has the property of stimulating the function

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

A. M. KENNEDY, M.D., M.R.C.P.

PROFESSOR OF MEDICINE, UNIVERSITY OF WALES, AND DIRECTOR
OF THE MEDICAL UNIT, WELSH NATIONAL SCHOOL OF
MEDICINE, CARDIFF

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