Correspondence

Specific food intolerance

SIR,—Farah *et al* (February issue) report a proven incidence of food allergy in 6% of patients in whom food intolerance was suspected as a cause of unexplained gastrointestinal symptoms and attribute symptoms in the remaining 94% to psychogenic causes.¹ They suggest that the lower positive diagnostic yield recorded in their study than in comparable studies by other workers is due largely to inter-study variation in criteria for selection of patients. It is also possible, however, that the discrepancy is a result of basic flaws in the design of their trial protocol.

Initially all patients were placed on a 'low allergenicity diet'. From our reading it would appear that *all* foods are potentially allergenic, and of the 19 foods permitted in the early stages of this trial we could find only four – salt and vinegar, prunes and apricot – which had not previously been observed to cause allergic responses in some subjects.^{2,3} A standardised exclusion diet is therefore impossible as one hallmark common to all previously published work in this field is the range and combinations of foods to which patients can be shown to respond.

In more rigorously controlled studies patients are given a severely restricted diet for two weeks consisting typically of one meat (lamb or chicken), one carbohydrate (potato or rice), one fruit (banana or apple), one vegetable (brassica), water and a vitamin supplement – the so called oligoantigenic diet. Patients who do not improve on this diet are offered a second such regime with no foods in common with the first diet.⁴

The failure of Farah *et al* to offer an alternative diet to those patients who did not respond to the initial dietary screening (73%) casts doubt on the adequacy of their trial protocol and on their conclusion that most forms of adverse food reaction can be attributed to psychogenic causes. We note that the results of this trial have already appeared in print⁴ in abstract form and that after publication similar criticisms of the initial screening diet were made.⁵

It is commonly assumed that the controlled clinical trial provides a careful and critical evaluation of the efficacy of new treatment regimes. However, inadequate trials, particularly in controversial areas of medicine, serve only to promote scepticism among clinicians and to lead patients to seek help from 'alternative' practitioners.

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References

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- 3 Lessof MH. Food intolerance and allergy – a review. *Q J Med* 1983; **206**: 111–9.
- 4 Farah DA, Calder I, Benson LH, Mackenzie JF. Specific food intolerance and gastrointestinal symptoms. [Abstract] *Scott Med J* 1983; **28**: 313–4.
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Reply

SIR,—In their comments on our paper on specific food intolerance, Drs Burford-Mason and Willoughby have misread our conclusions. Firstly, we did not claim an 'incidence' of specific food intolerance amongst our 49 patients and secondly, nowhere do we claim that symptoms were attributable to psychogenic cause in 94% of the patients. We specifically avoided reporting an incidence of specific food intolerance, as the study was not designed for that purpose. It would be wrong to draw any conclusions concerning the incidence of specific food intolerance for this reason.

In partial explanation of our low diagnostic yield (6%), our exclusion diet is criticised for being insufficiently rigorous. As most of the patients did not themselves suspect food intolerance at the outset, an acceptable and palatable exclusion diet was chosen (notwithstanding that we expected to 'miss' a few patients as a result). It was felt that compliance would suffer if the regimen was too rigorous, or too complicated.

It is certainly possible that an increased diagnostic yield would follow the use of a more rigorous dietary approach and our results should not deter those wishing to use such regimens. The only sure way, however, of excluding antigens from the diet is to use an elemental diet such as Vivonex, which is antigen-free. This may be regarded as too extreme to apply to a broad spectrum of patients, although it is an approach we have used clinically in selected cases. Any exclusion diet less rigorous than this will underestimate the incidence of specific food intolerance.

Finally in drawing attention to the greater number of placebo reactors than verified specific food intolerance patients, we did not intend the conclusion to be drawn that *all* the remaining patients'