

## **Current topic**

# Unorthodox allergy procedures

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Paediatricians are increasingly having to pick up the pieces when ventures into bizarre allergy treatment meet with disaster. This paper reviews some unorthodox allergy procedures in current use.

### **Urine treatment**

The patient's own urine is given orally, sublingually, intramuscularly, or topically.<sup>1</sup> The doses of urine for injection range from 2 ml for an infant to 8 ml for an adult. It is claimed that urine treatment can cure numerous diseases including eczema, asthma, and nocturnal enuresis. The concept of 'auto immune urine treatment', which has also been used to treat 'intra-familial sensitivity' (allergy to members of one's family),<sup>2</sup> is based on the theory that a therapeutic dose of antigen is excreted in the urine.

### **Applied kinesiology**

It is alleged that if an antigen to which a subject is allergic—for example, an egg—is held near the patient's body, placed in the patient's palm, or administered as drops under the tongue, it will instantly cause a pronounced loss of muscle power which is easily detectable by an observer. When a patient is too young to cooperate, a surrogate is used.<sup>3</sup> The surrogate is tested alone and then retested when holding the child's hand, the results for the two subjects being subtracted to show the patient's allergies.

### **Radionics**

Radionics is based on the concept that man is submerged in an energy field which lies beyond the electromagnetic spectrum and is therefore undetectable by scientific instruments. The patient does not need to be present for radionic diagnosis or treatment, for the doctor and patient are said to be connected by a beam of energy, along which information can be transmitted that is relevant to the patient's health. The method uses extrasensory

perception and a pendulum, accompanied by a 'witness' of the patient, usually a sample of hair.<sup>4</sup> Doctors with special gifts claim they can dispense with the pendulum and the witness, and test using merely the patient's name. It is said that radionics can be used for the detection of all allergies, for the diagnosis of virtually all common diseases, and also for the identification of most individual bacterial pathogens.

### **Pulse testing**

It is reported that a tachycardia occurring five to 90 minutes after exposure to a food or inhaled material is a reliable pointer to food allergy.<sup>5</sup> Others have suggested that a slowing of the pulse rate is equally diagnostic.

### **Auricular cardiac reflex testing**

It is claimed that if a substance to which a patient is allergic is brought within half an inch of the skin, then the auricular cardiac reflex (derived from a form of acupuncture) changes the wave form of the pulse at the wrist, enabling detection of the allergy. Such testing currently uses dried food samples mounted in specially prepared filters, and it is said that using this technique 50 foods or chemicals can be tested in 15 minutes.<sup>6</sup>

### **Vega testing**

A Vegatest device is used to detect changes in the resistance to the flow of electricity over acupuncture points on the ends of fingers and toes. This is brought about by bringing particular substances in glass phials into series in an electrical circuit. Vega testing is used to diagnose food allergy, chemical sensitivity, and 'organ stress'. It is reported that the observed changes in readings are partially psychokinetic effects and therefore dependent on the psyche of the practitioner.<sup>7</sup>

### Lymphocyte cytotoxicity

This test comprises the observation of morphological changes in white blood cells incubated simultaneously with a suspect antigen and a sample of the patient's serum.<sup>8</sup> The presence or absence and degree of damage caused to the leucocytes is claimed to be an indicator of the presence of food or chemical sensitivity, or both, and to give some indication of its severity.

### Enzyme potentiated transepidermal desensitisation

It is claimed that this technique exploits a potentiating effect of  $\beta$  glucuronidase when it is added to dilute allergen mixtures.<sup>9</sup> A small plastic cup containing the appropriate desensitising fluid is placed over an area of skin which has previously been scarified using a blunt scalpel. The cup is left in place for 24 hours. A mixture of more than 70 allergens may be applied in the hope that important ones have been included. Identification of all the patient's allergies beforehand is not necessary. It is said that benefit may not occur until 12 months or more after treatment has been given.

### Trace metal hair analysis

It is held that abnormal levels of trace metals may 'underpin' the development of food and chemical sensitivities.<sup>6</sup> Hair trace metal analysis is claimed to be a useful investigation in atopic disease, and any imbalance may be corrected by a mineral supplement.

### Intestinal candidiasis

In this supposed condition and the related entity 'dysbiosis', it is claimed that there is an imbalance of the flora of the gastrointestinal tract, which leads to a proliferation of *Candida albicans*. It is claimed that intestinal candidiasis can underlie food sensitivity and that such food sensitivity will not respond to a diet or desensitisation until the candidiasis itself has been diagnosed and treated.<sup>10</sup> Treatment is either with anti-*Candida* agents such as nystatin, or with sublingual drops.

### Intradermal skin testing

Unlike conventional intradermal allergy testing, with this method antigens are diluted to produce nine successively weaker concentrations and these are injected intradermally. A resulting weal is seen, and after 10 minutes assessed for lateral increase in size, blanching, hardness, and well demarcated

edges. A 'positive' weal is said to have retained most of these features and to have grown to at least 2 mm in diameter. It is reported that an injection of a concentrate may produce no reaction, whereas an injection of a dilute solution may result in a positive weal. It is further claimed that as the weal enlarges, symptoms related to the patient's complaint are provoked in 70% of subjects. Finally, it is held that if increasing dilutions are injected at half hourly intervals, when a dilution is reached which causes no weal, symptoms disappear at once.<sup>3 6</sup> This dilution is then used in neutralisation therapy.

### Oral or subcutaneous neutralisation

Having determined the neutralising dose, neutralising solutions of all the relevant antigens are combined and then given either by sublingual drops or by subcutaneous injection.<sup>3 6</sup>

### Sublingual provocation

One or more drops of a dilute solution of an antigen or suspect substance are given sublingually, and the patient observed for adverse effects indicative of allergy to the test agent.<sup>3</sup>

### Conclusions

The feature common to all the above diagnostic and therapeutic methods is that their general application to atopic disease, food allergy, and other disorders has not been validated objectively.<sup>11</sup> This has never even been attempted with most techniques, and where it has the studies are either unrepresentative or technically unsound.<sup>11-13</sup> There are other drawbacks to these methods: the inappropriate use of exclusion diets, often nutritionally inadequate, usually not supervised by a dietitian, and sometimes leading to severe malnutrition or persistent dietary obsession<sup>12</sup>; false diagnosis of disease where none exists—for example, North Sea gas allergy<sup>11 12</sup>; and great expense.<sup>11</sup>

In the United Kingdom unorthodox approaches are largely used by doctors without any specialist training, who operate from private allergy clinics where careful appraisal and follow up may not be carried out. The onus to prove the validity, if any, of these techniques lies with the proponents of such forms of diagnosis or treatment. All these methods must be regarded at best as experimental and their use confined to properly designed investigational studies.

### References

- 1 Armstrong J. *The water of life. A treatise on urine therapy*. 2nd ed. Saffron Walden: Health Science Press, 1981.

- <sup>2</sup> Wilson CWM. Allergic factors affecting the family. *Nutr Health* 1983;**1**:195–207.
- <sup>3</sup> Mumby K. *Allergies . . . what everyone should know*. London: Unwin, 1986.
- <sup>4</sup> Reyner JH, Laurence G, Upton C. *Psionic medicine*. 2nd ed. London: Routledge & Kegan Paul, 1982.
- <sup>5</sup> Coca AF. *Familial nonreaginic food allergy*. 3rd ed. Springfield: Charles C Thomas, 1953.
- <sup>6</sup> Lewith GT, Kenyon JN. *Clinical ecology*. Wellingborough: Thorsons, 1985.
- <sup>7</sup> Kenyon JN. *21st century medicine. A layman's guide to medicine of the future*. Wellingborough: Thorsons, 1986.
- <sup>8</sup> Black AP. A new diagnostic method in allergic disease. *Pediatrics* 1956;**17**:716–24.
- <sup>9</sup> McEwen LM, Starr MS. Enzyme-potentiated hyposensitisation. *Int Arch Allergy Appl Immunol* 1972;**42**:152–8.
- <sup>10</sup> Crook WG. *The yeast connection. A medical breakthrough*. 2nd ed. Tennessee: Professional Books, 1984.
- <sup>11</sup> David TJ. Unhelpful recent developments in the diagnosis and treatment of allergy and food intolerance in children. In: *Food intolerance: current research and paediatric practice*. Dobbing J, ed. London: Bailliere Tindall 1987:185–222.
- <sup>12</sup> David TJ. The overworked or fraudulent diagnosis of food allergy and food intolerance in children. *J Roy Soc Med* 1985;**78** (suppl 5):21–31.
- <sup>13</sup> Sethi TJ, Lessof MH, Kemeny DM, Lambourn E, Tobin S, Bradley A. How reliable are commercial allergy tests? *Lancet* 1987;**i**:92–4.

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