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VAN DIE REDAKSIE

WAT NIE DOOD MAAK NIE

‚Wat kan ek eet, Dokter?' Hoe dikwels het ons nie al daardie woorde gehoor nie, en hoe dikwels het ons nie al skynbaar geleerde raad gegee nie! Het ons al ooit 'n halwe vermoede gehad dat baie van ons raadgewings op niks grondiger as tradisie berus nie, en dat die tradisie ons al soms in die steek gelaat het? Hoewel die tradisie dikwels reg het, moet ons tog die feite wat ons dusver as onbetwisbaar aanvaar het, krities en met 'n bietjie meer wetenskaplike noukeurigheid ondersoek. Ons behoort te vra watter bewys daar is dat die voedsel wat 'n pasiënt meen dat hy kan geniet, hom inderdaad kan kwaad doen.

Daar is baie voor die hand liggende voorbeelde; laat ons 'n paar bespreek. Ons dink dadelik aan vetsug, wat byna altyd aan ooreet te wyte is. As vetsug die gesondheid benadeel—volgens die lewensversekeringskaarte is dit blykbaar die geval—dan kan dieetbeperking wel nodig wees. Suikersiekte is nog 'n uitstaande voorbeeld. Sommige skrywers raai wel aan dat suikersiektelyers 'n onbeperkte voedselkeuse toegelaat moet word, maar ten minste een van hulle het intussen sy woorde teruggetrek en teruggekeer na die streng beheer van die pasiënt se dieet.[1] Hoewel die feite nog 'n beslissing afwag, kan kroonslagaarsiekte en die vetgehalte van die dieet ook aangehaal word.

Jare lank is pasiënte met maag- en dundermsere met 'n streng beheerde voedselplan behandel. Baie van die ouer geneeshere sal die strafheid van die skrale dieet onthou. Die honger pasiënte het om kos gesmeek, maar dit is hulle streng verbied. Wat voedsel betref, was die saak maar haglik vir dié met bloeiende maag- en dundermsere—al wat hulle mondeliks kon neem, was ys om aan te suig. Die sterftesyfer was hoog. Toe het Meulengracht bewys dat beter resultate behaal kon word as die pasiënte 'n feitlik onbeperkte dieet toegelaat word. Die teenstrydigheid dat die pasiënt met die bloeiende maagseer groot en voedsame maaltye kon geniet terwyl die nie-bloeiendes liggaam en siel op brood en pap kos aanmekaar moes hou, was darem te ooglopend, en binnekort het die diëte meer toegewend geword. Die meeste geneeshere het nietemin daarop aangedring dat die voedsel ten minste sag en glad moet bly. Nou lyk dit asof selfs hierdie bepaling nie essensieel is nie. Dit is bewys[2,3] dat pasiënte wat die gewone hospitaaldieet mag hou, met inbegrip van rowwigheid—selfs ook vark-

EDITORIAL

A LITTLE OF WHAT YOU FANCY

'What may I eat, Doctor'? How often have we heard those words, and how often have we given apparently erudite advice! Have we ever had a lurking suspicion that much of what we are saying is based on nothing sounder than tradition, which has sometimes let us down? While tradition is often correct, it still behoves us to examine critically and with a little more scientific precision what we have hitherto accepted as unquestionable. We should ask what evidence there is that a food which a patient feels he can enjoy is in fact bad for him.

Many examples spring to mind; let us consider a few of them. Obesity is perhaps the most obvious one. It is almost invariably due to overeating. If obesity is harmful—and the life-insurance tables seem to show that it is—then dietary restrictions may be necessary. Diabetes is also a conspicuous example. Unrestricted choice of food has been advocated for diabetes by some authors but at least one of these has since recanted and gone back to a strict control of the patient's diet.[1] Coronary-artery disease and the fat content of the diet may also be quoted, though the facts are still *sub judice*.

For many years patients with gastric and duodenal ulcers were treated with a strict dietary regime. Many older doctors will recall the rigours of the sippy diet. Hungry patients clamoured for food, which was sternly denied them. For patients bleeding from these ulcers the outlook, dietetically speaking, was frightful—nothing by mouth except ice to suck. The mortality rate was considerable. It was then shown by Meulengracht that better results could be obtained if the patients were allowed what amounted almost to an unrestricted diet. The paradox that the patient whose ulcer was bleeding was allowed to eat large and substantial meals while the non-bleeding ulcer patient had to subsist on bread and slops was too obvious to be missed, and more liberal diets soon followed; but most doctors insisted, at least, that the bland and soft nature of the diet should be maintained. Now it appears as though even this is not essential. It has been shown[2,3] that patients who are allowed to have the usual ward diet, not excluding roughage—or even pork-pie—fared slightly better than those fed with the traditional 'bland'

pastei—ietwat beter gevaar het as dié wat die gebruiklike sagte kos gekry het. Daarvan is die verbasende afleiding gemaak dat die gebruiklike dieetkundige behandeling wat vandag vir maagsere toegepas word, nie die genesing van die seer bevorder nie, maar dit selfs kan vertraag. Pasiënte wat medies reeds goed ingeprent was met die idee van die ‚regte' dieet vir maagseerlyers, was 'n bietjie skrikkerig vir of selfs gekant teen die nuwe raad, maar toe hulle eers oortuig was, het genesing dikwels vinnig gevorder. Hulle kon die groter en meer bevredigende maaltye goed verdra en het klaarblyklik baat gevind daarby. Is streng dieetbeperkings dan nie nodig nie? Is dit nie miskien beter om die pasiënt voor te lig aangaande kossoorte wat miskien goed, of sleg, vir hom mag wees nie, en hom dan maar self te laat uitvind watter uitwerking hierdie kossoorte op sy simptome het nie? Elke ondervindingryke dokter het al pasiënte raakgeloop wie se maagsere genees het nieteenstaande die feit dat hulle geheel en al geen dieetbeperkings gehou het nie. Niemand sal 'n pasiënt aanraai om iets wat sy maag omkrap te eet nie; ons bedoel slegs dat die pasiënt soms beter as die dokter weet wat hy kan verdra.

Besmetlike lewerontsteking is 'n gelyksoortige saak. Elke mediese student ‚weet' dat vet hierdie pasiënte kwaad doen. Sodra 'n pasiënt met hierdie opskrif op sy bedkaart in die hospitaal opgeneem word, word hy outomaties op 'n vet-arm dieet geplaas. Baie van hierdie pasiënte kan inderdaad geen vet verdra nie. Die kwaai mislikheid maak selfs die blote gedagte aan vet afstootlik. Maar beteken dit dat vet nadelig is? Ons kry nie almal die geleentheid om hierdie saak op groot skaal uit te toets nie. So 'n geleentheid is egter onlangs gebruik, en 'n uitgebreide studie is daaroor gepubliseer.[4] Dit is bewys dat die beste dieet vir pasiënte met akute besmetlike lewerontsteking *nie minder* as ongeveer 3,000 kalorieë moet oplewer nie, en *nie minder* as ongeveer 150 gram elk proteïene en vet moet bevat nie. Bó hierdie hoeveelheid moet die inname *ad lib.* wees. Hoewel gebakte en vetterige kos spysverteringmoeilikhede kan veroorsaak, is die vette in vleis, eiers en suiwelprodukte nie nadelig by lewerontsteking nie, en dit dra immers baie by tot die smaaklikheid van die dieet. 'n Oormaat *proteïene* in die dieet kan nadelig wees vir 'n uiters siek pasiënt met 'n uitbarstende, heftige siekte of dreigende hepatiese koma, maar blykbaar ook net in hierdie soort geval. In die meeste gevalle sou dit waar wees om te sê dat die enigste belangrike ding is dat die pasiënt aanhou eet. Wat hy eet is van betreklik min belang. As hy wel vet kan verdra, is daar blykbaar geen rede waarom hy dit nie mag kry nie.

Kragtens hulle bevoorregte posisie is geneeshere in staat om die vryheid van hul pasiënte te beperk. Dit is belangrik dat die geneesheer se voorligting aangaande sy pasiënt se dieet net so modern en op hoogte van sake soos die res van sy praktyk moet wees. Op gebied van die dieetkunde is die dokter miskien gerade om 'n bietjie meer aandag aan sy pasiënt se smaak te bestee wanneer dit teenstrydig is met sy eie oorwegings.

1. Dunlop, D. M. (1954): Brit. Med. J., **2**, 383.
2. Lawrence, J. S. (1952): Lancet, **1**, 482.
3. Doll, R., Friedlander, P. en Pygott, F. (1956): *Ibid.*, **1**, 5.
4. Chalmers, T. C., Eckhardt, R. D., Reynolds, W. E., Cigarroa, J. G., Deane, N., Reifenstein, R. W., Smith, C. W. en Davidson, C. S. (1955): J. Clin. Invest., **34**, 1163.

diet. The surprising conclusion was reached that the dietetic treatment of pepic ulcer as at present practised does not hasten the healing of the ulcer and may even delay it. Some reluctance to follow the new advice, and even resistance, was met with in patients who had been medically indoctrinated with the 'correct' diet for ulcer patients, but once this had been overcome healing often proceeded apace. The larger and more satisfying meals were well tolerated and seemed to be beneficial. Are severe dietary restrictions then not required? Is it perhaps not better to indicate to the patient which foods might be helpful and which might be harmful and let him find out for himself what effect these foods have on his symptoms? Every doctor of experience has seen patients whose ulcers have healed despite the complete absence of dietary restriction. It is the rule rather than the exception. No one would advocate that a person should eat anything that upsets his stomach; what we mean to say is that the patient is sometimes a better judge of what he can tolerate than his doctor is.

A somewhat analogous state of affairs exists in infectious hepatitis. Every medical student 'knows' that fat is bad for patients suffering from this disease. No sooner does a patient come into hospital with this label on his bed-letter than he is automatically placed on a low-fat regime. Many of the patients are, in fact, intolerant of fat. The extreme nausea which goes with this disease makes even the thought of fat abhorrent. But does this indicate that fat is harmful? Opportunities for testing this out on a large scale are not available to all of us, but such an opportunity has recently been grasped and an extensive study published.[4] It has been shown that the optimum diet for patients with acute infectious hepatitis is one producing *not less* than about 3,000 calories and containing *not less* than about 150 grams each of protein and fat. Intake above this level should be *ad lib.* Although fried and greasy foods may cause indigestion, the fat contained in meat, eggs and dairy products is not harmful in hepatitis and adds greatly to the palatibility of the diet. An excessive amount of dietary *protein* may be harmful in critically ill patients with fulminating disease or impending hepatic coma, but apparently only in this type of case. In most cases it would be true to say that the only important thing is that the patient should continue to eat. What he eats is of relatively little importance. If he can tolerate fat there appears to be every reason to give it to him.

By virtue of their privileged position doctors are able to interfere with their patients' liberty of action. It is important that the advice they offer concerning their patients' diet shall be as modern and up to date as the rest of their practice. In the field of dietetics the doctor may perhaps be wise to pay a little more attention to the patient's likes and dislikes when these conflict with the doctor's own beliefs.

1. Dunlop, D. M. (1954): Brit. Med. J., **2**, 383.
2. Lawrence, J. S. (1952): Lancet, **1**, 482.
3. Doll, R., Friedlander, P. and Pygott, F. (1956): *Ibid.*, **1**, 5.
4. Chalmers, T. C., Eckhardt, R. D., Reynolds, W. E., Cigarroa, J. G., Deane, N., Reifenstein, R. W., Smith, C. W. and Davidson, C. S. (1955): J. Clin. Invest., **34**, 1163.