Pan-Allergies, Cold Extremities, and the Food–pain Connection: a Personal History

From adolescence onward, I lived with a cluster of puzzling symptoms: cold hands and feet, chronic fatigue, insomnia, extreme itching, recurrent headaches, wandering spinal pain, and the triple response of Lewis. These persisted through the 1960s, 70s, and 80s, shaping my daily life and professional experiences.

The cold extremities were particularly noticeable. As a chiropractor in the 1970s and early 1980s, I did not want to greet patients with cold hands. I often warmed them in a basin of hot water before appointments. When skiing I would often go in for lunch early because of cold hands and feet. At the time, I suspected a nutritional cause rather than a circulatory disease. Later, after eliminating dairy, gluten, and a few other foods, the cold extremities disappeared — even while skiing — which was a life-changing discovery.

Alongside these challenges, chronic fatigue and insomnia formed a second "triple syndrome" accompanying the Lewis phenomenon. Other conditions included:

- Extreme whole-body itching with red flares when scratched.
- Facial redness if I touched my face, which I learned to avoid in clinic.
- Esophageal reflux and occult blood in stool, later confirmed as H. pylori, successfully treated with targeted antibiotics.
- Recurrent headaches, neck pain, mid-back pain, and migrating low-back pain from around age 14–15.
- An allergist eventually described me as "pan-allergenic." My reactions extended beyond foods to include newsprint, chlorine, and cold. As a lifeguard certified with the NLS at 16, avoiding chlorine was impossible, so I switched to drinking and cooking with distilled water, and used a home distiller for many years.

Food Elimination and Symptom Relief

Completely avoiding all triggering foods was not feasible. I focused on the most practical: dairy first (relatively easy), wheat second (more challenging given North American food culture). Even this partial elimination yielded substantial rewards: disappearance of cold extremities during skiing and elimination of the Lewis skin reaction in clinic.

Today, at 77, I occasionally experience minor post-prandial, post-exertional, and cold-induced asthma-like symptoms — transient fluid in the upper lungs and nasal passages, cleared with a few coughs. These vary depending on meal size, food combinations, and eating pace.

Symptoms Improved or Resolved

1. Recurrent triple response of Lewis
2. Chronic fatigue
3. Insomnia
4. Cold hands and feet (even while skiing, dancing, or seeing patients)
5. Chronic itching
6. Facial blotching
7. Esophageal reflux
8. Recurrent headaches
9. Migrating spinal pain (neck, mid-back, low-back)
10. Abdominal tenderness
11. Asthma-like fluid congestion without wheezing
12. Severe nasal congestion during colds — which has not occurred at all for over 30 years

See **Physiological Considerations** below

I maintained a highly active lifestyle: water skiing, snow skiing, squash, tennis, cycling, rollerblading, scuba diving, keelboat racing, and social dancing. I believe the sustained increases in blood flow were protective. When COVID shut down these activities, my resilience noticeably declined.

Clinical Observations: The Tender Abdomen

After graduating in 1973, spinal manipulation was my primary practice focus. Deep abdominal palpation toward the psoas bursa often revealed marked tenderness, preventing full assessment. In my experience, abdomens should not be tender. After medical evaluation, tenderness that cannot be explained by pathology almost always indicates a digestive overlay. Treating spinal lesions provides temporary relief, but lasting improvement requires addressing the underlying FoodPainConnection in addition to the musculoskeletal issues.

Physiological Considerations

Over time, I explored physiological models that contextualized my systemic responses. Concepts such as **vagal, somatovagal, and vago-somatic reflexes**[1] provide a framework for understanding how food-triggered visceral signals can influence widespread autonomic responses — from skin reactions and vasomotor changes to fatigue and digestive–pain interactions.

The **vasovagal reflex**[2], often discussed in the context of syncope, illustrates the convergence of visceral and somatic afferents and modulation of autonomic outflow. Networked reflexes, including **somato-autonomic**[3] and **somato-vagal reflexes**[4], show how visceral stimuli can influence somatic tissues and autonomic regulation, affecting skin blood flow and muscle tone. Research on **brain–gut** communication and **vagovagal reflexes**[5] further supports how dietary antigens can trigger multi-system responses — precisely the phenomena I experienced. **Somato-autonomic reflex studies**[6] and the **viscerosomatic reflex**[7] explain how visceral signals influence muscle tone and somatic structures. Back in the late 1960s and early 1970s, studying these were part of the chiropractic curriculum and they gave me an awarness of the compications of food while I was learning the science on spinal manipulation.

Integrating Experience and Expertise

The **Pain Relief Diet** became central to my approach and identity. My MS in Biology helped me conceptualize possible mechanisms, yet formal instruction on food-mediated systemic pain was largely absent. Science often moves slowly when conditions are not immediately life-threatening, and there remains a persistent lag between emerging research, its appearance in textbooks, and its adoption into routine clinical protocols. As a result, in some areas physicians may still be practicing with information that is five to ten years behind the published science.

I recall a case from many decades ago involving a pregnant patient in my care. Her medical physician told her that if she continued seeing me, he would discharge her from his practice. This followed my suggestion that she begin folic acid supplementation several weeks prior to becoming pregnant, along with my giving her several current research articles to pass on to him. He rejected the recommendation and told her that folic acid supplementation was unnecessary.

When she reported this back to me, I suggested she ask whether she could instead take a standard multivitamin — one that contained 400 micrograms of folic acid buried in the ingredient list. He agreed to that. It was a modest compromise, but it was better than nothing.

I continued caring for her through three pregnancies because of her scoliosis. This occurred long before folic acid supplementation was routinely recommended to reduce the risk of neural tube defects such as spina bifida and cleft palate — a reminder of how long it can take for strong evidence to become standard medical practice.

Today

I now use the term **Wellness RISK** to describe preventable, measurable risk states that people can modify with guidance. This led to the development of **Wellness RISK Management**, a system that both **Measures RISK** and provides structured **Tutoring**. I see Canada as the world leader in **Wellness RISK Management**.

As I enter my later years, my goals are clear:

1. Launch **Wellness RISK Management** and the **WRM Instructor Program**.
2. Publish the third editions of my two Pain Relief Diet books.
3. Collaborate with researchers to bring scientific validation to these life-learned insights.

And finally — enjoy retirement, on my own very active terms.

Footnotes / References

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