Food intolerance has been the topic of discussion for a long time because of the confusion that occurs in most of the population by attributing to them the responsibility for abdominal disorders such as swelling, bloating, pain and/or alteration of the bowel habits after the assumption of certain foods, or more often weight increasing or metabolic diseases. Recently, there was an enormous diffusion, especially on the media (web and social networks), of restrictive diets based on diagnostic tests of “food intolerance” performed on different biological samples (blood, saliva, hair), as detoxifying remedies to the body. Some doctors in ancient Greece described cases of food adverse reactions but recent scientific studies have dated to the early 20th century.

The allergy is instead an expression of an abnormal answer of the immune system against harmless food, but recognized as harmful in some predisposed subjects. Typical symptoms of food allergies occur a few minutes or a few hours after the intake of the responsible food. According to epidemiological data, food allergies (AA) affect 5% of children under 3 years and about 4% of the adult population [1]. In the general population, the concept of “food allergy” is widespread (about 20% of the population feels that they are affected by food allergies). “perceived” food allergies, however, are not always real: self-evaluation data, ranging between 12.4% and 25%, are confirmed by the oral provocation test (TPO) only in 1.5-3.5% of the cases [2,3].

The available diagnostic tests for food allergy are: Skin tests (prick test, prick by prick, patch test); Serological tests for total IgE (PRIST) and specific (via ImmunoCAP or RAST) research; Molecular diagnostics; Double-blind Oral Provocation Test (TPO) versus placebo [4].

The definition of food intolerance is related to adverse reactions to foods occurring from a few hours to a few days after the intake, and unlike food allergies, they are not related to the production of a particular class of IgE antibodies (responsible for allergic reactions).

Symptoms include chronic diarrhea, abdominal swelling, vomiting, meteorism, abdominal cramps, migraine, but sometimes they overlap with those of a food allergy (such as urticaria, itching or tongue).

Food intolerances include: i) Enzymatic reactions, determined by the absence or deficiency of enzymes necessary to metabolize some substrates (e.g. lactose intolerance); ii) pharmacological reactions, responses...
to pharmacologically active food components, such as vasoactive amines (e.g., tyramine, histamine and caffeine) contained in fish, chocolate and fermented products, or substances added to foods (colorants, additives...); iii) indefinite responses, like psychological or neurological responses (food aversion or rhinorrhea) [5].

The diagnostic approach in suspecting a food intolerance is primarily based on anamnestic examination. Currently validated tests for diagnosis of food intolerances are: breath test for lactose intolerance, specific antibody assay, and endoscopic examination for gluten intolerance. For the diagnosis of pharmacological intolerances, the only approach is anamnestic but for those linked to undefined mechanisms it is possible to carry out the provocation test with the administration of the suspected additive [6].

Recently, however, the speculative fashion on intolerance led to the birth of unvalidated and expensive tests without any scientific evidence, which may delay a proper diagnosis and lead to exclusion of well-tolerated foods.

Unvalidated tests are: IGg4 assay, cytotoxic test, Alcat test, electrical tests (vega-test, Voll electroacupuncture, bioscreening, biostrengt test, sarm test, moratess test), kinesiologic test, hair analysis, iridology, Bioresonance, pulse test, ear cardiac reflex. The inappropriate use of these tests only increases the likelihood of false positives, resulting in unnecessary dietary restrictions and reduced quality of life [7].

Exclusion diets not adequately managed and monitored by a qualified healthcare professional can lead to nutritional risk and deficiencies, and poor growth and malnutrition in children, and they can increase the phenomenon of the “diet industry” and, moreover they cause a direct cost for patients / users and indirect for the National Healthcare System, as the diagnostic value of complementary/alternative tests for adverse reactions to food. Allergy 2005;60:1216-7.

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First of all, an adequate caloric intake is necessary, because whatever clinical expression is, it is a permanent condition. As with lactose, even in celiac disease, the industry today has made available a wide range of gluten-free products, but in order to improve its palatability, percentage fat and total calories are more than classic products. Considering that diet remains the only life-style therapy, it is crucial that the diet prefers naturally gluten-free (cereal) products [11].

Lactose-free foods are available on the market, allowing these patients to maintain their usual eating habits. Nutritional properties do not differ from lactose products [9,10].

Celiac disease is a permanent intolerance to gluten that causes, in genetically predisposed subjects, a chronic inflammatory reaction of the small intestine mucosa resulting in global malabsorption for progressive flattening up to the complete disappearance of intestinal wildlife. The only therapy is a strictly gluten-free diet that is to be followed throughout life because, whatever clinical expression is, it is a permanent condition. As with lactose, even in celiac disease, the industry today has made available a wide range of gluten-free products, but in order to improve its palatability, percentage fat and total calories are more than classic products. Considering that diet remains the only life-style therapy, it is crucial that the diet prefers naturally gluten-free (cereal) products [11].

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