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This month, I will discuss the fascinating and excellently done recent issue of the journal "Literature and Medicine." This issue's articles all address the nature of "fashionable diseases," that is, diseases with a "novel, modish prominence," that rose and fell in popularity over the decades during the eighteenth and nineteenth centuries (239, Andrews&Lawlor)[1]. The articles present arguments for why certain disease and not others became popular as well as what the suffers gained from assuming diagnoses such as, "general debility ("nervous weakness"), melancholia, gout, and biliousness" (272, Shuttleton)[2]. Often the suffers would gain, through their diseases, "symptoms that can be presented in a positive light for bestowing heightened creativity, greater emotional sensitivity, or finer social discrimination" (273, Shuttleton). Additionally, the disease could provide the suffer with greater control over his or her life. Mascha Hansen makes clear how poet Elizabeth Carter "did make use of her headaches to gain a little more independence for herself," allowing her to turn down social engagements and even "demand a room of her own, even a place apart from her friend's house" when visiting other cities, which ran directly contrary to eighteenth century etiquette (421-422, Hansen)[3]. Of course, along with the rise of these "fashionable" diseases came a new, strong skepticism that the "diseases were being exploited or even assumed for their positive connotations and status" (388, Monaghan)[4]. Much of the scholarship in this issue is devoted to the contemporaneous criticism and satire of these fashionable diseases, dealing with questions of the authenticity of the sufferers' experiences, the veracity of their purported symptomatology, and the motivation of the physicians who treated these fashionable diseases.

Given the rich parallels that could be drawn between eighteenth and twenty-first century "fashionable diseases," I would have liked to have seen more nods to modern-times, as Sander Gilman does in his brief examination of the legacy of fat-shaming in the eighteenth century on modern-day approaches to obesity (443, Gilman)[5]. I also would have appreciated a greater effort to distinguish the fashionable disease as a diagnosis from the underlying symptoms. David Shuttleton addresses this particular difficulty nicely, writing "Due attention to the 'ordinary' patient's experience as available in epistolary consultants and other archival material, is indeed essential but, in presuming to recover the felt 'reality' of a fashionable disease, we much surely tread with caution, bearing in mind theoretical questions regarding crude realism and matters of mediation. The charge of affectation implies an element of *self*-fashioning on the part of the fashionable sufferer…in some way disease does not exist until we have agreed that it does, by perceiving, naming, and responding to it" (280, Shuttleton). Certainly, the umbrella diagnoses that

were put over various symptoms were products of their cultural moment, but I find myself both intrigued and uncomfortable with questions like "to what extent are fashionable diseases merely cultural constructs?" (271, Shuttleton). I think in large part I am uncomfortable due to the plethora of real pathologies that were mislabeled under various "fashionable" diagnostic labels. A perfect example of this is multiple sclerosis (MS), which up until its characterization in living patients by Jean-Martin Charcot in 1868 was diagnosed as "hysteria" and *continued* to be misdiagnosed as hysteria well into the twentieth century. As Colin Talley notes in his article on the history of MS, "At the 1917 American Medical Association meeting, one physician pointed out 'the frequent mistaking of this condition [MS] for hysteria…in this condition [MS] we make many mistakes…[I] was often forced to revise [the] diagnosis of hysteria" (389, Talley)[6]. Historical examples like that of MS, as well as more the recent emergence of diagnoses like fibromyalgia and chronic fatigue syndrome, make me hesitant to read patient descriptions of symptoms as feigned or inauthentic; however, I find the argument that a patient would wish to have those particular symptoms diagnosed as a particular, fashionable disease very persuasive. As Katherine Allen writes of biliousness, a fashionable disease in the eighteenth-century, "Biliousness is illustrative of the notion that sufferers' interpretations of their symptoms were influenced by current rhetoric and cultural trends, hence pre-existing diseases and symptoms began to take on new fashionable meanings" (342, Allen).[7]

I would like to propose my own modern-day parallel to the fashionable diseases discussed in this journal. My example is "Chronic Lyme Disease" (CLD), a disease popularized by its remarkably high-profile celebrity spokespeople, including singer Avril Lavigne and Hadid sisters, as well as numerous other celebrities[8]. Despite a name that implies a similar microbiologic specificity to Lyme disease, CLD has "no clinical definition and is not characterized by any objective clinical findings. The only published attempt to define CLD provisionally produced a description too broad to distinguish CLD from myriad other medical conditions, and the case definition did not mention evidence of [Lyme] infection (2, Lantos)[9]. Already CLD seems reminiscent to me of the catch-all diagnoses like "biliousness" discussed in the journal. As a result, the almost unanimous opinion of infectious disease specialists is that—making no claims one way or the other about the lived *symptoms* of the patients—the *diagnosis* of CLD is nonsense. The also almost unanimous opinion of infectious disease specialists is that few doctors who diagnose and treat patients with CLD are charlatans. In this, I am reminded of Shuttleton's description of "the mutually reinforcing symbiosis between, on the one hand, medical gullibility fueled by social aspiration and affectation, and on the other the mercenary, exploitative machinations of a medical marketplace" (275, Shuttleton). Not only is the diagnosis of CLD not medically accurate, the treatment is often a long-term course of antibiotics, which studies have shown provided patients with no benefits, numerous treatment complications, even death, and represented poor antibiotic stewardship[10]. Again, I do not doubt the symptoms experienced by patients with so-called CLD, I do doubt, however, the diagnostic label they receive, and in many cases actively wish to receive, as they search for "Lyme literate" doctors. It is exactly as Shuttleton writes of eighteenth century "affluent aspirational patients [who] choose not only their practitioners but also their disease" (275, Shuttleton).

James Makittrick Adair, a doctor and critic of the "fashionableness" of disease, and a frequent source in many of the articles, notes that "before the publication of this book [on nervous diseases]…people of fashion had not the least idea they had nerves" (276, Shuttleton). This comment feels particularly well-suited to the celebrity-advertisements and glossy magazine articles extolling the (glamorous) horrors of CLD and the subsequent explosion of diagnoses of CLD.

Finally, CLD represents an interesting point in the history of fashionable diseases where increasingly patients and (the majority of) physicians are in direct opposition as to the existence[11] and diagnosis of particular "fashionable" diseases: CLD, adrenal fatigue[12], toxins, electromagnetic sensitivity, and non-celiac gluten-sensitivity[13], and no doubt others. Interestingly, however, *all* of the above are covered regularly in the media, attributed to celebrity patients, and presented as medically factual diagnoses. Perhaps it is worth thinking about the degree to which the modern-day media has eclipsed physicians as one half of that symbiotic partnership between medical gullibility and an exploitative marketplace.

Next month, I will again discuss this edition of "Literature and Medicine," looking at the gendered experiences of fashionable disease and authenticity as well as some modern-day parallels of these issues.

[1] Jonathan Andrews & Clark Lawlor, "Introduction 'An Exclusive Privilege…to Complain': Framing Fashionable Diseases in the Long Eighteenth Century." *Literature and Medicine*. 35.2 (2017): 239-269.

[2] David E. Shuttleton, "The Fashioning of Fashionable Diseases in the Eighteenth Century." *Literature and Medicine*. 35.2 (2017): 270-251.

[3] Mascha Hansen, "'All the World is Gone to the Assembly': Elizabeth Carter's Headaches, Nerves, and (In)Sociability." *Literature and Medicine*. 35.2 (2017): 409-435.

[4] Jessica Monaghan, "Authenticity and Fashionable Disease in Eighteenth Century Britain."*Literature and Medicine*. 35.2 (2017): 387-408.

[5] Sander L. Gilman, "The Fat Person on the Edgware Road Omnibus: Fat, Fashion, and Public Shaming in the British Long Eighteenth Century." *Literature and Medicine*. 35.2 (2017): 431-447.

[6] Colin Lee Talley, “The Emergence of Multiple Sclerosis, 1870-1950: A Puzzle of Historical Epidemiology,” *Perspectives in Biology and Medicine*. 48.3 (2005): 383-395.

[7] Katherine Allen, “Recipe Collections and the Realities of Fashionable Diseases in Eighteenth-Century Elite Domestic Medicine,” *Literature and Medicine*. 35.2 (2017): 334-354.

[8] http://people.com/bodies/celebs-who-have-lyme-disease/

[9] Paul M Lantos, MD, “Chronic Lyme Disease,” *Infect Dis Clin North Am*. 29.2 (2015): 325-340.

[10] MS Klempner et al, “Two controlled trials of antibiotic treatment in patients with persistent symptoms and a history of Lyme disease,” *New England Journal of Medicine*. 345.2 (2001): 85-92.

[11] Much like the anti-vaccine movement, CLD is full of celebrity endorsements and anti-scientific conspiracies. Dr. Paul Lantos, an infectious disease specialist at Duke University, writes that the CLD advocacy community argues that “the general scientific and public health establishments ignore or even cover up” evidence of the existence of CLD (Lantos, 2).

[12] Flavio A Cadegiani et al, “Adrenal Fatigue Does Not Exist: a Systematic Review,” *BMC Endocr Disord* 16.1 (2016): 1-16.

[13] However, some studies have shown that a sub-population of people diagnosed with non-celiac gluten-sensitivity may actually be experiencing irritable bowel syndrome in response to wheat breakdown products, not gluten