

The Body Has a Hidden Triage System

Absurd Health Institute · Hypothesis and mechanistic perspective

Central hypothesis

An injured organism may divert resources away from reproduction, growth or nonurgent performance toward maintaining perfusion, glucose supply, immune defense and immediate survival. This is not a claim that organs consciously vote; it is a proposal that interacting endocrine and neural signals create a functional hierarchy of demand. The critical novelty is to study failures of *return* to ordinary allocation after a threat ends.

The biological route

Inflammation can reduce appetite and increase hepatic acute-phase synthesis; sympathetic and HPA-axis output redistributes cardiovascular demand; severe illness changes muscle proteolysis and substrate allocation. A tissue-level signal can therefore have remote energetic consequences. One can imagine a regulatory network responding to inflammatory cytokines, leptin, insulin, glucocorticoids and autonomic afferents in concert, rather than each signal commanding a single organ. A persistent signal may stabilize an initially useful allocation at substantial long-term cost.

An illustrative scenario

Suppose a patient with a serious infection sleeps poorly, loses appetite and temporarily experiences reduced exercise capacity. Those changes can be maladaptive in excess but may also accompany cytokine-mediated prioritization of host defense. A useful causal diagram would chart the degree of infection, the autonomic and endocrine response, the cost in skeletal muscle and cognition, and the point at which recovery of ordinary function should begin. The critical observation is not that symptoms occur together, but whether their timing follows an identifiable regulatory response.

Alternative explanations and limits

The strongest objection is that what looks like strategic reallocation may simply be nonspecific sickness behavior, drug effects or organ injury. The metaphor of triage can conceal heterogeneity and lead to teleological claims that biology never demonstrated. Acute tradeoffs should not be assumed in all chronic diseases.

What would change the conclusion?

An informative comparison would track energy expenditure, hormone rhythms, muscle turnover and functional recovery across an acute illness and convalescence. The theory weakens if the presumed hierarchy cannot predict which functions are suppressed, or if each change is explained better by independent tissue injury. The timing of reversal is as important as the initial response.

The distinctive prediction

If this is a true allocation program rather than a coincidental cluster of symptoms, suppressed functions should return in a reproducible sequence as the threat subsides. That sequence would provide stronger evidence than simply observing temporary fatigue or appetite loss during infection.

Clinical interpretation

Clinically, distinguishing a protective allocation from a pathological continuation matters because neither indiscriminate stimulation nor deliberate deprivation is automatically appropriate. The concept is a map for questions, not a protocol or a justification for withholding treatment. It helps ask when the initiating threat is gone but an organism remains organized around emergency.

Selected scientific reading

Contextual background, not direct validation of the proposed hypothesis.

McEwen BS. Stress, adaptation, and disease: Allostasis and allostatic load. *Ann N Y Acad Sci.* 1998.
<https://pubmed.ncbi.nlm.nih.gov/9629234/>

Pyrkov TV et al. Longitudinal analysis of blood markers reveals progressive loss of resilience and predicts human lifespan limit. *Nat Commun.* 2021.
<https://www.nature.com/articles/s41467-021-23014-1>

Editorial note: Original theoretical perspective, not an original clinical study, validated diagnosis, or treatment protocol.