Repeated upper gastrointestinal investigations all showed an ulcerative lesion of the duodenum. After a gastroduodenoscopy which confirmed the presence of a duodenal ulcer of linear type, he was on oral cimetidine, 200 mg three times a day and 400 mg at bedtime continuously during the last three months, with only mild relief of his pain. A new endoscopic examination on 6 November showed that the duodenal ulcer had become a roundish lesion (mean diameter 5 mm). Two weeks after beginning this therapy the patient had noted the appearance of gynaecomastia and breast pain and, after a few more days, the development of erythrosis-like skin lesions. These were all over his body but more evident on the trunk, and there was no prurigo. The gynaecomastia and skin manifestations began to disappear within two weeks after he stopped taking cimetidine.

No change in biochemical and haematological values was observed and no other drug was being taken by the patient in this period. There is no evidence to suggest that the erythrosis-like skin lesions were other than a cimetidine-induced phenomenon like gynaecomastia, which is a well-known side effect of the drug and probably due to an increase of serum prolactinaemia.^{1,2}

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¹ Burland, W L, *et al*, *British Medical Journal*, 1978, 1, 717.

² Cavallini, G, *et al*, in abstract of VI World Congress of Gastroenterology, Madrid, June 1978, p 18.

Pyritinol hydrochloride (Encephabol) and senile dementia

SIR,—In the *BMJ* of 3 March, p 601 a reply was made to the question "What is the latest treatment for and the role of vasodilators in treating senile dementia? Has Encephabol/pyritinol hydrochloride/ any part to play?" An opinion was given concerning pyritinol, and at the end of the answer several statements were made which require clarification.

The clinical value of pyritinol is questioned in the article on the basis that Martindale does not list any of the papers demonstrating its efficacy in senile dementia which were published after 1969. In fact the most important body of publications demonstrating clinical efficacy appeared after this date. We are in the process of asking the publishers of Martindale's *Extra Pharmacopoeia* to update the list of references.

Pyritinol is not a vasoactive substance or a vasodilator. However, it has been shown that cerebral blood supply is increased by pyritinol and that this pyritinol-induced increase can be regarded as a consequence of the improvement of nerve cell metabolism.¹ This improvement in nerve cell metabolism has been demonstrated by several authors.²⁻⁴ The clinical efficacy of pyritinol has been demonstrated in more than 20 controlled studies in patients with various forms of organic brain disease (full references available). The results of one such double-blind trial in matched groups of elderly patients with senile dementia showed that pyritinol was significantly superior to placebo in improving their physical activity, alertness, mental power, and interest.⁵

Finally, we should point out that pyritinol is widely prescribed in Eire as well as the countries listed by your contributor. It is not, however, on sale in the UK and therefore it is

not surprising that Hyams does not mention Encephabol in his textbook *Geriatric Medicine and Gerontology*.

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¹ Herrschaft, H, *Münchener Medizinische Wochenschrift*, 1978, 39, 1263.

² Quadbeck, G, *Progress in Brain Research*, 1962, 349.

³ Stoica, E, *et al*, *Neurology*, Minneapolis, 1973, 23, 687.

⁴ Hoyer, S, Oesterreich, K, and Stoll, K D, *Arzneimittel-Forschung*, 1977, 27, 671.

⁵ Hamouz, W, *Pharmatherapeutica*, 1977, 1, 398.

Thrombocytopenia and splenic infarction

SIR,—In reply to the correspondence (17 March, p 748) about our reported case of renal carcinoma (10 February, p 381), we would like to state that we still consider that the patient's thrombocytopenia had no clear cause. In our report the statement that a diffuse intravascular coagulation screen was normal should, in our opinion, leave little doubt that a chronic consumption coagulopathy had been eliminated. Limitations of space prevented us from describing in detail in the report the tests performed—but thrombin time, prothrombin time, partial thromboplastin time, and fibrin degradation products were estimated on a number of occasions while the patient was thrombocytopenic and were always normal. The fibrinogen was consistently slightly raised.

We also felt that hypersplenism had been eliminated, because although it was possible to palpate the spleen at the time of death this was due to its displacement by the left renal mass. In fact, the spleen weighed 200 g at necropsy and, except for its posterior aspect, where it was involved in the necrotic tissue, the splenic histology was normal. We stated in our report that multiple, small, wedge-shaped infarcts were seen in the spleen, and these were in relationship to the necrotic tissue. Gross splenic infarction did not occur; otherwise as a result we might have seen a raised platelet count, as suggested by Dr D O Ho-Yen.

Since our purpose in describing this case was to draw attention to what we considered to be a unique case, we are not surprised that it does not fit the descriptions seen in standard haematological reference books.

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Suction termination of pregnancy under local anaesthesia

SIR,—Local anaesthesia (about 18-20 ml of 1% lignocaine plus adrenaline, injected at the 12, 4 and 8 o'clock positions) gives adequate relief of pain due to dilation of the cervix. However, it is clear that there is a component of pain caused by uterine contractions, which can be severe in a minority of patients, some of whom find it unacceptable although quite short lived. It is usually described as being similar to dysmenorrhoea.

Mefenamic acid, a powerful inhibitor of prostaglandin synthetase, is highly effective

in the relief of primary dysmenorrhoea.¹ We have tried the effect of 500 mg of mefenamic acid (Ponstan) as premedication about 1½ hours prior to suction termination with a Karman catheter under local anaesthesia. In a series of 25 women I have been impressed by the improved analgesia this provides, particularly during the last few moments of the procedure, when dysmenorrhoea is normally marked. I am in the process of arranging a double-blind randomised study of premedication with this agent, assessing the amount of pain experienced by visual analogue scales and card-sorting procedures; but my colleagues and I are so convinced by the clinical evidence of its efficacy that I felt it justifiable to write this preliminary communication. The combination of mefenamic acid and cervical anaesthesia with lignocaine is so effective that it seems unnecessary to use general anaesthesia up to 10 weeks of gestation for any but the most anxious patients.

Nevertheless, the tradition in most units in this country of using general anaesthesia (and, even more unnecessarily, overnight stay following the procedure) will, I am sure, prove difficult to abandon.

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¹ Anderson, A, *et al*, *Lancet*, 1978, 1, 8060.

Hulka-Clemens clips

SIR,—Mr N R A Trickey's letter (31 March, p 894) cannot go without comment. It is indeed unfortunate that Mr Trickey seeks to damn a method of female sterilisation on such flimsy evidence.

The results of two multicentre prospective trials carried out in the United Kingdom using this method of tubal occlusion reported a failure rate of less than two per 1000.^{1,2} Worldwide experience with this clip confirms its unique safety as it avoids both haemorrhage from the mesentery and diathermy trauma to the bowel.³ For these reasons those working at the Samaritan Hospital were proud to append the hospital's name to the clip applicator.

This method of sterilisation is now being used with increased frequency in the United Kingdom and Europe. Although the operation is quick and easy to perform it does require meticulous attention to detail. For this reason I suggest that those learning the technique should apply two clips to each fallopian tube in their first 100 cases.

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¹ Lieberman, B A, *et al*, *Journal of Reproductive Medicine*, 1977, 18, 241.

² Lieberman, B A, Gordon, A G, and Wright, C S W, in *Endoscopy in Gynecology*, ed J M Phillips, p 182. Downey, California, American Association of Gynecological Laparoscopists, 1978.

³ Hulka, J F, *et al*, *American Journal of Obstetrics and Gynecology*, in press.

Breakage of Falope-ring applicator forceps prongs

SIR,—We have been using the silastic band technique in conjunction with the Falope-ring applicator (KLI Inc, Newtown, USA) for laparoscopic surgery since 1975. So far, we have encountered three instances where the tip of one of the prongs on the applicator forceps has broken at surgery; this unusual complication and its management has not to