graft tissue, skin, to an abnormal culture atmosphere (45% CO₂ in air) for various periods (7-48 h). Normally-cultured skin grafts caused no lymphoid malignancy. Immunogenicity of exposed grafts as a result of modification of cell-surface proteins and production of "altered self" structures may be a factor in the subsequent appearance of lymphoma in these autologous hosts.

In the animal models described above, malignant lymphoma develops as a late sequela of transplantations in the absence of exogenous immunosuppressants; chronic antigenic stimulation appears to be a possible common factor. Significantly, only lymphoid neoplasms developed despite the grafting of four different tissues—lymph node, mammary gland, skin, and bone marrow. Bone marrow is the only tissue that did not induce lymphoma in its recipients even following exposure to an unphysiological environment. This raises the question whether the T lymphocytes in the graft tissues are involved in the malignant processes in these animal models.

A E GOLDSMITH

National Cancer Cytology Center,
Melville, New York

G F RYAN

Brookhaven Memorial Hospital
Medical Center,
Patchogue, New York

A B JOSEPH

St Catharine's College,
University School of Clinical
Medicine, Cambridge

¹ Armstrong, M Y K, Schwartz, R S, and Beldotti, L,
Transplantation, 1967, 5, 1380.

² Goldsmith, A E, and Ryan, G F, in *Prevention and
Detection of Cancer*, ed H E Nieburgs, p 971. New
York, Marcel Dekker, 1977.

³ Von Boehmer, H, and Byrd, W J, *Nature New Biology*,
1972, 235, 50.

⁴ Von Boehmer, H, and Adams, P B, *Journal of
Immunology*, 1973, 110, 376.

⁵ Goldsmith, A E, and Narvaez, R, *Oncology*, 1975, 32,
247.

Polymyalgia rheumatica and primary biliary cirrhosis

SIR,—May we comment on the paper by Dr J C Robertson and others (21 October, p 1128)? We have reported the careful rheumatological examination of 88 patients suffering from biopsy-proved primary biliary cirrhosis.¹ We found a much higher prevalence of rheumatic disorders than Sherlock and Scheuer² but did not find any patient who had the classical polymyalgia rheumatica syndrome. Polymyalgia rheumatica can be a difficult condition to diagnose, especially in patients who already have many other problems, but we took special care to elicit symptoms of stiffness and pain in the joints and muscles.

We did see three main rheumatological complications: scleroderma, avascular necrosis of the femoral or humeral head, and inflammatory arthritis. At that time we felt that the inflammatory arthritis was probably no greater than would be seen in a comparable population of middle-aged women. Further experience has suggested to us that we may not have been correct in this assessment and we hope to be reporting further on the inflammatory arthritis in primary biliary cirrhosis; but we doubt that the polymyalgic syndrome occurs sufficiently frequently in primary biliary cirrhosis to be an important association. We would also offer a word of caution about treating patients with corticosteroids with a doubtful diagnosis of polymyalgia as there is a real danger of accelerated osteoporosis.

However, we would make the point that

patients presenting with a somewhat atypical rheumatological complaint should have, among other investigations, liver function tests performed with a view to the possibility that this might be an unusual manifestation of primary biliary cirrhosis.

A K CLARKE
ERIC HAMILTON
ROGER WILLIAMS

King's College Hospital,
London SE5 9RS

¹ Clarke, A K, *et al*, *Annals of Rheumatic Diseases*, 1978,
37, 42.

² Sherlock, S, and Scheuer, M D, *New England Journal
of Medicine*, 1973, 289, 674.

Homoeopathic medicine

SIR,—Dr Hamish W Boyd's letter (24 March, p 821) is an extension of the old homoeopathic search for respectability.

Formation of a faculty, registration by Parliament, or registrable diplomas do not remove homoeopathy from fringe medicine. Those who feel that there may be a scientific basis for it should read recent publications on the subject such as those by Blackie¹ and by Ruthven Mitchell.² Both of these books speak a different language and indicate how little insight homoeopathic practitioners have into the powers of suggestion.

R S WALKER

Glasgow G3 7TD

¹ Blackie, M, *The Patient Not the Cure*. London,
MacDonald and James, 1977.

² Mitchell, G R, *Homoeopathy*. London, W H Allan,
1977.

Postpartum haemorrhage and induction of labour

SIR,—We presented a paper (23 September 1978, p 855) showing an increased incidence of postpartum haemorrhage following induced labour compared with spontaneous labour. Additional data for the years 1975-7 from St Mary's Maternity Hospital, Portsmouth, confirm this finding.

A total of 10 320 spontaneous vaginal deliveries occurred in this three-year period, of which 6462 were spontaneous labours and 3858 were induced or accelerated labours. The accompanying table shows the figures for each year with the overall postpartum haemorrhage rate for the 10 320 cases. Multiparous and primiparous patients have been analysed separately, as they were in the initial study. The difference in postpartum haemorrhage rates between the induced and spontaneous groups is striking.

There has been no major change in the management of labour since our original paper was published. Intravenous prostaglandins have been used rarely for induction of labour. The oxytocin regimen remains unchanged and Syntometrine (ergometrine maleate and oxytocin) continues to be given for the third stage of labour.

MacKenzie (17 March, p 750) has confirmed our findings in his survey of delivery figures

from Oxford. He has in addition been able to show the figures for accelerated labour as a separate category, which show a postpartum haemorrhage rate between that of spontaneous and induced labours.

We present these figures in support of our previous submission that postpartum haemorrhage should be considered as a serious complication of induction of labour, especially in primigravidae, and that it is probably related to the dosage of oxytocin infused.

P R BRINSDEN

Royal Naval Hospital,
Gosport, Hants

A D CLARK

St Mary's Maternity Hospital,
Portsmouth, Hants PO3 6AD

Male sexual dysfunction and cimetidine

SIR,—I read with interest Dr N R Peden and colleagues' report (10 March, p 659) about three patients with sexual dysfunction after cimetidine and their postulation of an anti-androgenic action for cimetidine in man. It is worthy of comment that in two patients (cases 1 and 3) the luteinising hormone (LH) and follicle-stimulating hormone (FSH) levels were higher off cimetidine treatment and that the level of these hormones fluctuated at three and seven months after treatment in case 2. The data presented seem rather sparse to suggest overall trends.

Dr A M Hoare and I¹ were unable to find any differences in prolactin, total androgen, and oestradiol levels, or in the response of LH, FSH, and thyroid-stimulating hormone to appropriate releasing-hormone stimulation in 10 male subjects tested before and at completion of a 12-week course of cimetidine (1600 mg per day). Patients' ages ranged from 29 to 76 years (mean 50). Moreover, the lack of significant change is not altered by omitting those patients who were less than 40 years old.

It seems unlikely therefore that there is an endocrinological basis for the impotence reported by Peden *et al*, although other mechanisms may indeed be operating in the aetiology of this distressing complaint.

S G BARBER

The General Hospital,
Birmingham B4 6NH

¹ Barber, S G, and Hoare, A M, *Hormone and Metabolic
Research*, 1979, 11, in press.

Cimetidine and erythrosis-like lesions

SIR,—A 36-year-old man was admitted to our clinic on 2 November 1978 with a history of epigastric pain. Over the past 10 years he had had recurrent epigastric pain and three episodes of gastrointestinal bleeding after taking anti-inflammatory drugs.

Postpartum haemorrhage (PPH) rates in induced and spontaneous labours: Portsmouth, 1975-7

Year	Spontaneous labour				Induced labour				Total
	Primiparae		Multiparae		Primiparae		Multiparae		
	Total No	No (%) with PPH	Total No	No (%) with PPH	Total No	No (%) with PPH	Total No	No (%) with PPH	
1975	731	27 (3.7)	1217	46 (3.8)	629	46 (7.3)	931	57 (6.1)	3508
1976	908	40 (4.4)	1451	62 (4.3)	448	37 (8.2)	702	49 (7.0)	3509
1977	838	33 (3.9)	1317	44 (3.3)	436	35 (8.0)	712	39 (5.5)	3303
Total	2477	100 (4.0)	3985	152 (3.8)	1513	118 (7.8)	2345	145 (6.2)	10320

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}

GIAMPAOLO ANGELINI
PAOLO BOVO
BRUNA VAONA
GIORGIO CAVALLINI

General Medical Clinic,
University of Padua at Verona,
37100 Verona, Italy

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*.

MICHAEL K FLOOD

E Merck Ltd,
Alton, Hants GU34 5HG

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.

PETER WILMSHURST

St Thomas's Hospital,
London SE1 7EH

K R MILLS

University College Hospital,
London WC1E 6AU

Y J DRABU

Northwick Park Hospital,
Harrow, Middx HA1 3UJ

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.

JOHN GUILLEBAUD

The Hospital for Women,
London W1V 6JB

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.

B A LIEBERMAN

Saint Mary's Hospital,
Manchester M13 0JH

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