Letters to the Editor

New marker of B lymphocytes

In a recent article by Hall *et al*¹ we were surprised to read an unsubstantiated claim that the immunogold-silver (IGSS) method is not suitable for routine use. In our experience the method is as simple to perform as indirect immunoperoxidase, and unlike the latter technique, requires neither inhibition of endogenous tissue components nor potentially carcinogenic reagents. Furthermore, costing of the method, as used routinely in a busy district general hospital, has shown it to be about half as expensive as a standard immunoperoxidase technique. Because of its much enhanced sensitivity in routine use, the method proves more reliable than immunoperoxidase and is often much faster to perform.

In Leeds the same primary antibodies evaluated by Hall *et al* are used regularly except that they are applied for one hour with IGSS instead of overnight as required for indirect immunoperoxidase. While methods requiring prolonged incubation of primary antibody can be conveniently used for research purposes, they may result in serious delays in a diagnostic setting. We would therefore suggest that the authors should advocate use of the IGSS technique as a more practicable alternative to their method.

To our knowledge, the IGSS method has already been introduced into pathology laboratories in several district general hospitals and judging from the response to the first IGSS Users' Group meeting held recently in Leeds, we believe that more laboratories will be adopting the method soon.

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Reference

- 1 Hall PA, D'Ardenne AJ, Butler MG, Habeshaw JR. New marker of B lymphocytes, MB2: comparison with other lymphocyte subset markers active in conventionally processed tissue sections. *J Clin Pathol* 1987;40:151-6.

Dr Hall and colleagues comment:

We were interested to read the letter of Holgate *et al* on the routine use of the IGSS method. Our comments were based on our own experience of this method at the time the MB2 study was initiated. We have found the indirect peroxidase method simpler to use in a diagnostic laboratory, mainly because distilled and deionised water is not essential and because the method is not light sensitive. We use overnight incubation with primary antibodies not because it is essential with this method but because it allows higher antibody dilutions to be used and minimises expenditure. While we appreciate that a more sensitive method such as IGSS may have a similar advantage, we have not found that the delay causes problems in the diagnostic setting. In fact, the practice fits in well with our laboratory routine.

We understand that new reagents are now available which overcome our previous objections, and we are happy to accept the assertions of Holgate *et al* that the IGSS method may be suitable for routine use. We should like to emphasise, however, that the prime purpose of our paper was not to discuss the relative merits of immunostaining techniques but rather to assess the diagnostic value of a monoclonal antibody.

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Use of mefenamic acid

May I compliment Dr Isaacs and his colleagues on the clinical thoroughness with which the two unfortunate elderly women were investigated.¹ I am sure that the skill and diligence shown by his team in relieving their long standing medical complications is appreciated by the two patients.

The one area where I do have concern with the paper is in the balance chosen when criticising mefenamic acid. This medicine has been on the United Kingdom market for almost 25 years and in that time millions of patient years of treatment have been given. During this time, Parke-Davis has striven to reflect changes in medical practice and in medical knowledge in its approved data sheet labelling. To quote from a recently published review of the adverse reactions to non-steroidal anti-inflammatory drugs, "To discard old drugs because we are so much aware of their toxicity might in fact prove undesirable without further knowledge of the safety of the newer agents in comparison with the older traditional drugs".²

We counsel caution when mefenamic acid is used in the elderly with dehydration or renal disease, and advise that serious renal or gastrointestinal problems may arise if only warning concerning discontinuation of the drug after the onset of diarrhoea is ignored. We warn that the diarrhoea may start after some months of otherwise uneventful administration and clearly state that patients who once develop diarrhoea should never again receive mefenamic acid. Unfortunately, despite all of the above, these two unlucky women continued to receive mefenamic acid long after the onset of the absolute contraindication, one for eight years after developing steatorrhoea and the other for 15 months. Goodman and Gilman (sixth edition) has been used as the sole reference to the efficacy of mefenamic acid. There are, in fact, a host of studies³ comparing mefenamic acid favourably in terms of efficacy or tolerance with many of the commonly used non-steroidal anti-inflammatory drugs.

These points are offered as constructive comment, and I would suggest that Dr Isaac's conclusions regarding mefenamic acid are inappropriate. Ponstan has been used safely and effectively to bring pain relief to many thousands of elderly sufferers. There is, however, a keen responsibility on all prescribing physicians to use potent medicine intelligently and in line with manufacturers' recommendations.

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References

- 1 Isaacs PET, Sladen GE, Filipe I. Mefenamic acid enteropathy. *J Clin Pathol* 1987;40:1221-7.
- 2 Weber JCP. Epidemiology in the United