was receiving placebo. Three patients stopped the treatment because of side effects while taking Seatone. One had headaches; one abdominal pain, diarrhoea, and headaches; and one constipation. Additional minor side effects were reported by two patients receiving Seatone and four receiving placebo. One patient was withdrawn from the study for reasons unrelated to treatment.

Comment
These results show clearly that a single course of Seatone was not superior to a fish extract in rheumatoid arthritis. Previous evidence for the effectiveness of Seatone is slender. The anti-inflammatory activity shown by Miller and Ormrod was obtained by intraperitoneal and not oral administration. Intraperitoneal administration of chemicals may have a spurious anti-inflammatory effect and is therefore unreliable. The effects in patients shown by Gibson et al were slight. Their study remained double-blind for only three months, during which time 10 out of 17 patients with rheumatoid arthritis receiving Seatone improved compared with three out of 11 receiving placebo. This difference is not statistically significant ($z^2 = 2.67, p > 0.1$). The results of measurements of pain, stiffness, and articular index were not given for patients receiving placebo, and no other evidence was put forward to show that Seatone was superior to placebo.

A four-week course of Seatone does not appear to be worth while except for the very considerable placebo effect that any new treatment has in rheumatoid arthritis.

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2 The Daily Telegraph 1980;Sept 12.

Systemic side effects with eye drops
One advantage of topical preparations of drugs is the lack of systemic side effects. Ecotothiopate eye drops are sometimes used in the treatment of glaucoma. Ecotothiopate is an anticholinesterase, and systemic cholinergic effects may occur.

Case report
The patient, a 59-year-old man, presented in 1980 complaining of excessive sweating of increasing severity for two years, which was most troublesome after meals and during the night. He also complained of intermittent diarrhoea for 10 years. This had been investigated in 1974 and no definite cause found. It had been adequately controlled with codeine phosphate. He had also noticed muscle weakness and fatigue for two years. He was completely blind as a result of glaucoma, for which he had been using “eye drops” since the age of 29 years. Apart from blindness no abnormal physical signs were apparent on examination. The following investigations were performed and yielded normal results: full blood count and erythrocyte sedimentation rate, blood urea and electrolyte concentrations, glucose tolerance test, thyroid function tests, urinary 4-hydroxy-3-methoxy mandelic acid, gastrointestinal hormone assays (vasoactive intestinal polypeptide, pancreatic polypeptide, gastrin, and glucagon), and barium meal and follow-through. He was treated with prepaenthine with minimal improvement.

Two months later it was suggested he stop using pilocarpine, one of his eye drops. He had no ill effects from this and so took it on himself to stop using his other eye drops—namely, Phospholine Iodide 0.25% (ecothiopate). All his symptoms—the hyphoprosis, muscle weakness, fatigue, and diarrhoea—resolved and he was able to stop taking the codeine phosphate. On reintroducing ecotothiopate he noticed a return of postgustatory sweating; he stopped using these drops again and remained well and asymptomatic.

Tetracycline-induced oesophageal ulceration
Oesophageal ulceration associated with ingestion of tablets is being increasingly recognised. Drugs already well known to be implicated are eperonium bromide and slow-release potassium. We report a case of oesophageal ulceration after ingestion of a tetracyline hydrochloride tablet.

Case report
A previously fit 24-year-old Iraqi man with no history of upper gastrointestinal disease or oesophageal motility disorder was given a seven-day course of tablets containing 250 mg tetracycline hydrochloride for a chest infection. He was taking no other medication. On one occasion he swallowed a single tablet without water at 1 am, after which he went immediately to bed and slept. He was awakened at 4 am with severe epigastrian and later retrosternal pain unrelied by water, milk, or antacids. He took no further tetracycline tablets and presented to the casualty department eight hours later still complaining of pain and odynophagia. Examination revealed only epigastrian tenderness. He was referred to a medical outpatient clinic and seen two days later, by which time the epigastrian pain had settled but odynophagia continued. There were no abnormal physical signs.

Investigations showed haemoglobin concentration to be 14+ g/dl; a chest x-ray film was normal. Fibreoptic endoscopy revealed localised ulceration of the left lateral oesophageal wall 28 cm from the incisors. Oesophageal mucosa above and below this lesion was normal, as were the stomach and duodenum. Biopsy specimens of the ulcer showed pyogenic granulation tissue consistent with an inflammatory ulcer. No specific treatment was given and repeat endoscopy three weeks later showed the lesion to have healed without stricture formation.

Comment
Tetracycline hydrochloride tablets have been cited as a cause of oesophageal ulceration in two American cases, but both patients were young women and each had a hiatus hernia. No such hernia existed in our patient, but in all three cases the history was similar in that the offending tablet had been taken just before sleeping and the patient had awakened a few hours later with severe retrosternal pain.