medium to anaerobic organisms that quickly invade the uterine cavity in the early puerperium.[3] When a patient known to have fibroids develops symptoms and signs of endometritis after delivery she should be treated initially with antibiotics appropriate to anaerobic organisms. In some cases, such as in our case 1, specimens for culture cannot be obtained. Treatment should then be started on suspicion of anaerobic infection alone.

We thank Professor W Gavin for allowing us to report case 1.

[1] Jeffcoate, T N A, in *Principles of Gynaecology*, 4th edn, p 426. London, Butterworth, 1975.
[2] Finegold, S M, in *Anaerobic Bacteria in Human Disease*, p 363. New York, Academic Press, 1977.
[3] Willis, A T, in *Anaerobic Bacteriology: Clinical and Laboratory Practice*, 3rd edn, p 215. London, Butterworth, 1977.

(*Accepted 20 August 1979*)

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Prazosin and priapism

Priapism, persistent painful erection of the penis, is rare but has many causes including drugs, particularly the phenothiazines.[1] How phenothiazines cause priapism is not clear but has been attributed to their ability to block alpha-adrenergic receptors. Parasympathetic dominance seems to encourage erection, and sympathetic blockade seems to inhibit ejaculation and detumescence.[1] We report on two patients who developed priapism while taking prazosin for hypertension. This drug, the first of a new class of antihypertensive agents, interferes with alpha-adrenergic function at the postsynaptic level.[2]

Case reports

Case 1—A 43-year-old West Indian was found to be hypertensive in 1976 and treated initially with propranolol 160 mg and hydrallazine 25 mg both thrice daily. Because his blood pressure was not well controlled prazosin was substituted for hydrallazine at a dose of 6 mg daily and gradually increased to 20 mg daily. Three months after starting prazosin the patient experienced the first of three episodes of priapism, which lasted for six hours and which he did not report to his doctor. He had no history of genitourinary disease. He was admitted with a painful sustained erection that had lasted for 30 hours. Examination showed an erect penis with tense and tender corpora cavernosa but flaccid glans and corpus spongiosum. The scrotal contents and the prostate were normal. The abdomen and the central nervous system were also normal. His blood pressure was 180/120 mm Hg. Investigations showed: haemoglobin 16·2 g/dl; white cell count $11{\cdot}6 \times 10^9$/l with a normal differential count; erythrocyte sedimentation rate 5 mm in the first hour; sickle-cell trait on haemoglobin eletrophoresis; blood urea concentration 2·8 mmol/l (16·9 mg/100 ml); liver function tests normal; syphilis serology negative; no protein, casts, or cells on urine analysis, and the urine was sterile. The patient was initially but unsuccessfully treated with ancrod. Subsequently the corpora cavernosa were drained and the penis became flaccid. His postoperative course was complicated by pulmonary infarction. His blood pressure was later adequately controlled with atenolol and bendrofluazide. The patient was still impotent after four months.

Case 2—A 43-year-old West Indian was found to be hypertensive in 1977. He was started on prazosin treatment in December 1977 at a dose of 1·5 mg daily, and this was increased gradually to 18 mg daily by the end of January. In early February the patient reported that he had on three separate occasions experienced painful spontaneous erections lasting up to nine hours. He had no history of genitourinary disease, and physical examination was unremarkable. Routine blood tests were normal, the sickle-cell screening test was negative, and haemoglobin electrophoresis was normal. Urine analysis showed 5-10 white blood cells in a high-power field, but no protein or casts; the urine was sterile. Intravenous urography was normal. The prazosin was stopped, and his blood pressure was controlled with propranolol, triamterene, and hydrochlorothiazide. In the 18 months since prazosin was stopped priapism has not recurred.

Comment

Sexual dysfunction, particularly impotence and failure of ejaculation, is a well-recognised side effect of some antihypertensive drugs that interfere with autonomic function. Priapism has been described in patients taking guanethidine, and the direct-acting vasodilator hydrallazine.[3] Sexual difficulties are said to be rare with prazosin although "congestion of (the) penis" has been attributed to the drug in one case.[4] Priapism associated with prazosin has not previously been reported.

Prazosin is thought to produce alpha-adrenergic blockade in a different way from the classical alpha-blockers phenoxybenzamine and phentolamine.[2] The unusual side effects of prazosin, frequency of micturition and incontinence of urine, have been attributed to this alpha-blocking action.[5] We now consider priapism a potential hazard of treatment with prazosin.

The weak association of sickle-cell trait and priapism may have contributed to the irreversible priapism in case 1. Prazosin should perhaps be avoided in men with the sickle-cell trait.

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[2] Graham, R M, and Pettinger, W A, *New England Journal of Medicine*, 1979, **300**, 232.
[3] Rubin, S O, *Scandinavian Journal of Urology and Nephrology*, 1968, **2**, 81.
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[5] Thien, T H, *et al*, *British Medical Journal*, 1978, **1**, 622.

(*Accepted 21 August 1979*)

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Vancouver style

All manuscripts submitted to the *BMJ* from now on should conform to the uniform requirements for manuscripts submitted to biomedical journals (known as the Vancouver style).

The *BMJ*, together with many other international biomedical journals, has agreed to accept articles prepared in accordance with the Vancouver style and will be introducing the system from January 1980. The style (described in full in *BMJ*, 24 February, p 532) is intended to standardise requirements for authors and covers text format, presentation of methods and results, use of SI units, and the form of tables and illustrations. All the participating journals have also agreed to introduce a standard form of references.

In future references to papers submitted to the *BMJ* should include: the names of all authors if there are fewer than seven or, if there are more, the first three followed by *et al*; the title of journal articles or book chapters; the titles of journals abbreviated according to the style of *Index Medicus*; and the first and final page numbers of the article or chapter.

Examples of common forms of references are:

[1] International Steering Committee of Medical Editors. Uniform requirements for manuscripts submitted to biomedical journals. *Br Med J* 1979;**1**:532-5.
[2] Soter NA, Wasserman SI, Austen KF. Cold urticaria: release into the circulation of histamine and eosinophil chemotactic factor of anaphylaxis during cold challenge. *N Engl J Med* 1976;**294**:687-90.
[3] Weinstein L, Swartz MN. Pathogenic properties of invading microorganisms. In: Sodeman WA Jr, Sodeman WA, eds. *Pathologic physiology: mechanisms of disease*. Philadelphia: W B Saunders, 1974:457-72.

Up to the beginning of October some 100 journals had agreed to accept articles in the Vancouver style, and a full list will be printed early in 1980.