# This week in BMJ

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US second class postage paid at Rahway, NJ. Postmaster: send address changes to: BMJ, c/o Mercury Airfreight International Ltd Inc, 2323 Randolph Avenue, Avenel, NJ 07001, USA. US subscription $146.

Published by the proprietors, the British Medical Association, Tavistock Square, London WC1H 9JR, Telephone 01 387 4499, and printed by Pulman Web Offset Ltd. Typesetting by Bedford Typesetters Ltd, Bedford. Registered as a newspaper.

## Asthma before school

Asthma in children of preschool age is often more severe and less responsive to treatment than asthma in older children. Trials of prophylactic agents (including inhaled steroids, which are of proved value in older children and adults) have produced comparatively disappointing results in children of this age. Children as young as 2 years, however, can use the Nebuhaler, a large pear shaped structure with a one way valve. At p 163 Gleeson and Price report the first trial to show a clear benefit from the use of an inhaled steroid in children under the age of 6 years. When the children were receiving budesonide by Nebuhaler the morning and evening peak expiratory flow rates were substantially higher and the children needed less additional treatment with bronchodilator drugs. No evidence of systemic corticosteroid effects were found after six weeks. A comparatively high dose of budesonide was tested, however, and the possibility of systemic effects after long term administration cannot yet be dismissed. A smaller dose of budesonide than that used in this trial may be sufficient in many cases, and the dose should be the smallest that controls the asthma.

## Oxytocin and normal third stage of labour

At the end of the second stage of labour the standard practice in Britain is to inject into the mother a mixture of oxytocin and ergometrine (usually as Syntometrine) in the belief that this reduces the risks of both postpartum haemorrhage and retained placenta. The treatment was introduced many years ago without any formal controlled clinical trials and its value has recently been questioned.

An assay is now available for measuring the plasma concentration of oxytocin, and Thornton *et al* (p 167) have been able to show that when synthetic oxytocin is not given some women produce adequate amounts of natural oxytocin but others do not. They studied only 25 women, but the results suggest that there is indeed a sound basis for current practice.

## Risk of suicide in young men

Suicide is one of the commonest causes of death in young adults, and its rate is increasing in many countries. Yet little is known about the precipitating factors. At p 176 Allebeck *et al* describe a unique study from Sweden in which they analysed extensive psychological data collected on over 50 000 young conscripts in 1969-70 as part of the selection procedure for military training. During 13 years of follow up 683 conscripts died, 247 by suicide. Strong correlations between suicide and lower intelligence, poor emotional control, and lack of social maturity were seen, poor emotional control being the most predictive factor. Other relevant factors included contact with the police or welfare authorities, lack of friends, and misconduct at school. No suicides occurred in the few subjects with schizophrenia or affective psychoses, but a high rate (30/1000) was recorded among intravenous drug users. Although the data cannot be used to predict suicides among the general population because of low specificity, the findings are likely to facilitate the identification of potential suicide victims in services dealing with a high concentration of people at risk.

## Flosequinan for heart failure

Of the drugs currently available for treating severe heart failure, the angiotensin converting enzyme inhibitors are probably the most effective. They do not, however, produce improvement in all patients and they may also be limited by side effects.

Cowley and his colleagues (p 169) have investigated a new mixed arteriolar and venous vasodilator, flosequinan, in two groups of patients with severe heart failure. In one group it produced favourable acute changes in central haemodynamics. In the other it improved various measurements, including exercise tolerance, that relate to the symptomatic impairment of patients with severe heart failure. An important finding was that it did not cause reflex neurohumoral stimulation. Flosequinan was investigated under the clinical trial exemption scheme of the Department of Health and Social Security and has yet to be evaluated by the Committee on the Safety of Medicines. Nevertheless, it appears to have the right properties for an alternative drug to angiotensin converting enzyme inhibitors in the treatment of severe heart failure.

## Familial hypercholesterolaemia

Familial hypercholesterolaemia is the best defined of the diseases that produce hypercholesterolaemia in humans and was the first genetic disorder recognised as causing myocardial infarction. Heterozygotes have a 50% chance of dying from myocardial infarction before the age of 60, and homozygotes rarely survive to the third decade. Familial hypercholesterolaemia is one of the more common disorders carried on a single gene: it has an incidence of one in 500 and about 100 000 people in Britain are affected.

The disorder results from a defect in the cell surface receptor that normally controls the degradation of low density lipoprotein cholesterol, the main transport lipoprotein for cholesterol in human plasma. The effect of this abnormality is to raise plasma concentrations of low density lipoprotein. Deposits of cholesterol derived from low density lipoprotein are formed in various sites, especially tendons (forming xanthomas) and arteries (causing atheroma).

Treatment of these patients is usually difficult because diet alone is not enough and even the most potent hypolipidaemic agents used singly often fail to produce satisfactory reductions in the low density lipoprotein cholesterol concentration. At p 173 Curtis *et al* report a trial in 18 patients of a combination of cholestyramine and bezafibrate, which showed that the two drugs combined gave better results than either alone.

# Instructions to authors

*The BMJ has agreed to accept manuscripts prepared in accordance with the Vancouver style[1] and will consider any paper that conforms to the style. More detailed and specific instructions are given below.*

All material submitted for publication is assumed to be submitted exclusively to the *BMJ* unless the contrary is stated. All authors must give signed consent to publication. The editor retains the customary right to style and if necessary shorten material accepted for publication.

Manuscripts will be acknowledged; letters and obituaries will not be unless a stamped addressed envelope is enclosed.

Original articles are usually up to 2000 words long, with no more than six tables or illustrations; they should normally report original research of relevance to clinical medicine and may appear either as Clinical Research papers or in the Papers and Short Reports section. Short Reports are up to 600 words long, with one table or illustration and no more than five references. Clinical case histories and brief or negative research findings may appear in this section. Papers for the Practice Observed section should cover research or any other matters relevant to primary care. Medical Practice articles are mostly written by invitation, but we welcome reports of up to 2000 words on the organisation or assessment of medical work and on sociological aspects of medicine. Talking Point articles are concerned with the organisation, financing, and manpower of health services. Contributions for the Personal View and Materia Non Medica columns are always welcome and should contain up to 1150 and 400 words respectively. Letters should normally be of not more than 400 words, have no more than 10 references, and be signed by all authors; preference is given to those that take up points made in contributions published in the journal.

Any article may be submitted to outside peer review and evaluation by the editorial committee as well as statistical assessment incorporating the use of published checklists.[2] This should take four weeks but may take up to six. Manuscripts are usually published within three months of the date of final acceptance of the article.

## Manuscripts, tables, and illustrations

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Drugs should be referred to by their approved, not proprietary, names, and the source of any new or experimental preparations should be given. Abbreviations should not be used. Scientific measurements should be given in SI units, but blood pressure should continue to be expressed in mm Hg.

Statistical methods should be defined in the methods section of the paper and any not in common use should be either described in detail or supported by references. General guidelines on the use of statistical methods and on the interpretation and presentation of statistical material have been published.[3,4] Tables and illustrations should be submitted separately from the text of the paper, and legends to illustrations should also be typed on a separate sheet. Tables should be simple and should not duplicate information in the text of the article. Illustrations should be used only when data cannot be expressed clearly in any other way. When graphs, scattergrams, or histograms are submitted the numerical data on which they are based should be supplied; in general, data given in histograms are converted into tabular form. Line drawings should be in Indian ink on heavy white paper or card, with any labelling on a separate sheet; they may also be presented as photographic prints or good quality photocopies. Other illustrations should usually be prints—not negatives, transparencies, or *x* ray films; they should be no larger than 30×21 cm (A4) and be trimmed to remove all redundant areas; the top should be marked on the back. Staining techniques of photomicrographs should be stated. An internal scale marker should be included on the photomicrograph. Again, any labelling should be on copies, not on the prints. Patients shown in photographs should have their identity concealed or should give their written consent to publication. If any tables or illustrations submitted have been published elsewhere written consent to republication should be obtained by the author from the copyright holder (usually the publisher) and the authors.

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1 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.

2 Osler AG. *Complement: mechanisms and functions*. Englewood Cliffs: Prentice-Hall, 1976.


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1 International Committee of Medical Journal Editors. Uniform requirements for manuscripts submitted to biomedical journals. *Br Med J* 1988;296:401-5.

2 Gardner MJ, Machin D, Campbell MJ. Use of check lists in assessing the statistical content of medical studies. *Br Med J* 1986;292:810-2.

3 Altman DG, Gore SM, Gardner MJ, Pocock SJ. Statistical guidelines for contributors to medical journals. *Br Med J* 1983;286:1489-93.

4 Gardner MJ, Altman DG. Confidence intervals rather than P values: estimation rather than hypothesis testing. *Br Med J* 1986;292:746-50.