This week in BMJ

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Cigarette smoking and perinatal mortality

Perinatal mortality rates have decreased dramatically in the developed world since the second world war. In the early 1950s in Sweden 30 infants per 1000 died within the perinatal period, while in 1980 the corresponding figure was 7 per 1000. Swedish health workers are now asking what possible preventive measure could reduce perinatal mortality further.

At p 258 Cnattingius *et al* look at smoking. They used data from the Swedish Medical Birth Registry, which prospectively collects details of all Swedish births. They looked at births in Sweden from 1983 to 1985, in all more than 280 000. The study concludes that smoking is probably the most important preventable risk factor for late fetal death and may also have an influence on early neonatal death. The authors estimate that the late fetal death rate would be reduced by 11% and early neonatal mortality by 5% if smoking could be eliminated from the pregnant population.

Lithotripsy and percutaneous surgery in treating renal calculi

Shock wave lithotripsy has been hailed as a major advance in the treatment of patients with kidney stones (and is now being evaluated for gall stones, too). So good were the early results that many surgeons rejected calls for clinical trials. Nevertheless, not everyone was convinced, and at p 253 Mays *et al* describe a (non-randomised) trial of extracorporeal shock wave lithotripsy and percutaneous nephrolithotomy in the removal of renal calculi. Over 1000 patients were assessed, and the results show that more of those treated surgically were free of single stones at three months (86%) than those treated by lithotripsy (58%). The mean length of stay in hospital was eight days for lithotripsy and nine days for nephrolithotomy. Critics may argue that these results for lithotripsy are not representative of those obtained in some specialist units, but the authors believe that in such reports less stringent criteria may have been used. The *BMJ* expects a lot of letters.

Risk of agranulocytosis and aplastic anaemia in relation to use of antithyroid drugs

The common antithyroid drugs are all known to be toxic to the bone marrow, with agranulocytosis a comparatively common side effect and aplastic anaemia a rare one. These risks have been known for nearly 50 years but few attempts have been made to quantify them. At p 262 the International Agranulocytosis and Aplastic Anaemia Study reports data from eight countries covering a population of 23 million. The excess risk of agranulocytosis from an antithyroid drug was calculated to be 6·3 cases per million users per week. Only four patients were identified as having taken antithyroid drugs and later developed aplastic anaemia. Because so few patients were identified the excess risk was not calculated; but the data suggest that it is very low.

Immunisation of neonates at high risk of hepatitis B in England and Wales

The earlier in life infection occurs with hepatitis B the more likely it is that the infected person will become a persistent carrier. This makes vertical transmission of hepatitis B (from mother to infant) an important public health problem, even in countries such as Britain with a low carrier rate. At p 249 Polakoff and Vandervelde describe the Public Health Laboratory Service programme of passive and active vaccination and report its results from 1982 to 1987. The outcome has been mostly satisfactory; 90% of fully immunised infants had high levels of protective antibody at 1 year. Nevertheless, consultants in only half the NHS hospitals with obstetric departments are collaborating with the programme.

INSTRUCTIONS TO AUTHORS

The BMJ has agreed to accept manuscripts prepared in accordance with the Vancouver style (BMJ, 6 February 1988, p 401) and will consider any paper that conforms to the style. More detailed and specific instructions are given below.

The following are the minimum requirements for manuscripts submitted for publication.

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

Authors should give their names and initials, their posts at the time they did the work, and one degree or diploma. All authors must sign their consent to publication.

Three copies should be submitted. If the manuscript is rejected these will be shredded.

Typing should be on one side of the paper, with double spacing between the lines and 5 cm margins at the top and left hand side of the sheet.

SI units are used for scientific measurements, but blood pressure should continue to be expressed in mm Hg.

References must be in the Vancouver style and their accuracy checked before submission.

Letters to the editor submitted for publication must be signed personally by all authors, who should include one degree or diploma.

The editor reserves the customary right to style and if necessary shorten material accepted for publication.

Detailed instructions are given in the *BMJ* dated 2 January 1988, p 48.