This week in BMJ

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Risk factors for infection with HIV among European expatriates in Africa

In most of Europe, AIDS and infection with human immunodeficiency virus (HIV) are still fairly unusual in heterosexual men and women (except for those infected by drug abuse or by contaminated blood products). In Belgium nearly one third of cases of AIDS among Europeans are in heterosexual men and women, most of whom are presumed to have been infected in central Africa.

On p 581 Bonneux *et al* describe a study from Antwerp showing that about 1% of Belgians living in central Africa are infected with HIV. From a case-control study it seems that almost all of the men with antibody to HIV acquired their infection by vaginal intercourse, particularly with prostitutes. European expatriates living in Africa may represent an additional source of infection in the heterosexual population in Europe.

Viral infection in pregnancy

Several acute infections, such as malaria, chickenpox, polio, and smallpox, have been reported to be more severe in pregnant than non-pregnant women, but published data derive mostly from anecdotal information or limited series. Few papers have reported prospective data related to gestation of pregnancy or titres of virus.

Lassa fever is a widespread and severe viral infection in rural west Africa, where it is responsible for an estimated 500 000 infections and 3000 deaths each year. The Centers for Disease Control (p 584) have been operating a research project in Sierra Leone since 1976, where despite limited facilities since 1981 they have obtained prospective clinical and laboratory data on 68 pregnant women with a single viral infection and a similar number of non-pregnant controls. The results show that Lassa fever is a major cause of maternal death and that pregnant women are at increased risk during the third trimester compared with non-pregnant women and women in the first two trimesters. This risk is associated with high serum titres of virus. The maternal prognosis was improved if the woman aborted or was delivered, and the study showed a benefit from active obstetric intervention, including surgery. The risk to the fetus remained high, with an 87% loss of fetuses and neonates. No hazard to hospital staff was observed when barrier nursing techniques were strictly enforced.

Diabetes in Indians

Indians migrating to other parts of the world are prone to develop diabetes, and particularly high prevalences of maturity onset diabetes have been found in Indians living in Fiji, South Africa, Trinidad, and Britain. In India itself diabetes was formerly thought to be uncommon, and a study in 1975 showed a prevalence of only 2·8%. Two years ago, however, a survey published in the *BMJ* showed that diabetes was no less common in New Delhi than among Indians in Southall, London. On p 587 Ramachandran *et al* report a survey of an urban population in south India in which they screened every fifth inhabitant aged over 20 for diabetes. Five per cent of the population had frank diabetes and a further 2% impaired glucose tolerance. These figures reached nearly 10% when adjusted for the older average age of Indians in Southall and Fiji. The authors also found a family predisposition and a positive correlation with income. The findings strongly suggest that diabetes is getting more common in India as affluence and longevity increase. It is a disease unmasked by improved living standards and well on its way to becoming a major public health problem.

Preserve the prepuce

The standard treatment for a small boy whose foreskin does not retract is circumcision—which may be distressing and will certainly cause some discomfort. Surgery for this condition may now, however, be outdated. On p 590 MacKinlay describes the use of Emla local anaesthetic cream as an alternative to circumcision. The cream gives enough anaesthesia for the adhesions to be broken down using a probe or gauze swab. So far 39 boys aged 2-12 have been treated; only one still needed circumcision.

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.