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.

More on fibre and diabetes

Diets high in carbohydrate and fibre and low in fat are widely recommended for diabetics as they are thought both to improve control and to reduce cardiovascular complications. These diets are often suggested for type II (maturity onset) diabetics for whom treatment with hypoglycaemic agents has not provided adequate control. Claims have been made that many of these patients could be "rescued" by paying adequate attention to their diets, so avoiding the need for insulin. Suspicious of this view—as such high carbohydrate, high fibre diets have been proved beneficial only in short term studies in well controlled patients—Scott *et al* (p 707) carried out a sequential investigation in poorly controlled patients. They treated the patients firstly with a high fibre diet plus oral hypoglycaemic agents, secondly, with a dose of basal insulin once daily, and, thirdly, with a regimen of insulin four times daily. Each succeeding regimen was dependent for its introduction on the failure of the preceding one. They found a frank deterioration in glycaemic control on the high fibre diet but a satisfactory improvement in most patients on insulin, though at the expense of some weight gain. The authors conclude that the present dietary recommendations are unrealistic.

Prolonged pregnancy: the management debate

A paper published by the *BMJ* in 1986 suggested that the outcome of pregnancies of greater than 42 weeks' duration was no worse if labour began spontaneously than if it were induced. In that study Ms Cardozo and her colleagues analysed the outcomes of an "active" and a "conservative group" on the basis of intention to treat.

Since then Drs Lang and Lieberman have suggested further analysis to take account of the delay of several days between the allocation to the "active" group and the induction of labour (p 715). During this time spontaneous labour may have begun, labour been induced for medical reasons, or women refused the treatment assigned to them—all of which would have affected the outcome.

On page 715 Pearce and Cardozo report that further analysis of their data not only supports their original conclusion but also suggests that routine induction of labour at 42 weeks' gestation may increase the need for operative delivery for fetal distress.

Predicting the incidence of AIDS

The AIDS epidemic is still at an early stage in its development. It is difficult to predict on the basis of currently available data how many people will develop AIDS over the coming years; yet health authorities want to have some idea of the likely needs in their local areas. On p 711 Tennison and Hagard describe and classify the various methods that have been suggested for modelling the epidemic. They select and explain a method which can be used to estimate the number of cases likely to be seen in a district over the next five years. They also give national predictions of case numbers over the same period.

Body mass and prostatic cancer

We know little about the causes of prostatic cancer other than the bald facts that its incidence increases sharply with age and that blacks seem to have higher rates than whites. Several recent epidemiological studies have shown that men with an increased body mass may be at increased risk. These studies have been limited to simple measures such as the body mass index, which is a composite measurement of all body tissues. At p 713 Severson *et al* report taking this line of investigation one step further by evaluating the separate effects of fat and muscle tissue. They found that Japanese men living in Hawaii who had increased muscle tissue had an increased risk of prostatic cancer, but that the amount of body fat had no effect. This is the first report of such an association, and—as is so often the case—more research will be needed.

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.

Abbreviations should not be used in the text.

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

Statistical procedures should be described in the methods section or supported by references.

References must be in the Vancouver style and their accuracy checked before submission. They should be numbered in the order in which they appear in the text.

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 and to determine the priority and time of publication.

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