This week in BMJ

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DNA fingerprinting as a rapid typing system for identifying outbreaks of systemic candidiasis

Preventing nosocomial infection should always be a high priority and never more so than when cross infection occurs among immunocompromised patients due to a pathogen such as *Candida albicans*. Systemic candidiasis is associated with a mortality of over 70%. Since the description of the first outbreak in 1985, four further outbreaks have occurred. Prompt implementation of cross infection control measures can prevent deaths, but early identification of outbreaks has been hampered by lack of a suitable typing system. On p 354 Matthews and Burnie report using DNA fingerprinting as a typing system, which they believe represents a crucial step towards solving the problem. Whereas existing typing systems are slow and need to be used in combination, DNA fingerprinting gave highly reproducible, fast results and could normally be used alone reliably to identify an outbreak. As DNA diagnostic services as well as research laboratories are being set up throughout Britain, the authors envisage that DNA fingerprinting will be used increasingly to identify outbreaks.

Monitoring levels of thyroid stimulating antibodies in Graves' disease

Agreement is lacking over how long patients with Graves' disease should be treated with antithyroid drugs. Many doctors prescribe "fixed term" periods of treatment, accepting that the price of preventing relapses in some patients will unnecessarily prolong treatment in others. Edan *et al* (p 359) describe how monitoring of thyroid stimulating antibodies could be used to tailor the duration of treatment for individual patients. They compared patients with Graves' disease whose treatment was stopped as soon as the antibody could not be detected with patients who still had the antibody when their treatment was stopped after 18 months (their usual regimen). Stopping treatment when thyroid stimulating antibody could not be detected halved the usual duration of treatment, and patients in this group had only half the risk of relapse of that of patients in whom the antibody persisted.

Spina bifida occulta

Until recently spina bifida occulta had been thought to be a chance radiological finding with no clinical implications. In 1985 an association was suggested between this type of bony defect and dysfunction of the lower urinary tract. This relation has been examined in greater detail by Fidas *et al* (p 357), who looked at radiographs of the spine in 138 patients with urodynamic disorders and compared the results with those of previous control series. Spina bifida occulta was found to be two to three times more prevalent in patients with urodynamic disorders than in controls. The next step is further investigation of these patients to see whether they have lesions (possibly amenable to treatment) causing pressure or traction on the lower spinal nerves.

Eye signs in familial adenomatous polyposis

Families of people known to have familial adenomatous polyposis are usually screened for signs of the disease by yearly sigmoidoscopy or colonoscopy. Chapman *et al* (p 353) examined the possibility of using a recently described ophthalmological finding to screen family members at risk of the disease. They found that all their patients with known familial adenomatous polyposis had two or more areas of hypertrophy of the retinal pigment epithelium, but none of their controls had more than two. Combining funduscopy with analysis of pedigrees and studies of DNA may allow non-carriers to be identified confidently, so saving them 30 years of endoscopy; subjects in whom multiple areas of hypertrophy are found may be more likely to comply with bowel examination.

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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 7 January 1989, p 40.