This week in BMJ

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Social class and mortality from cystic fibrosis

Thirty years ago most patients with cystic fibrosis died in childhood; now most live into adulthood. This improved survival represents a success of medical management and gives grounds for increasing optimism for the patients, their parents, and their doctors. Because the best survival has been obtained in large specialist centres it is widely believed that patients managed there have a better life expectancy than patients managed in local facilities. As a result there is increasing pressure from within the medical profession to expand the role of specialist regional centres in the management of cystic fibrosis in the United Kingdom.

On p 483 Britton argues that at least some of the apparent difference in survival between specialist and local care is due to differences in social class among the populations of patients. He analysed age at death from cystic fibrosis in England and Wales from 1959 to 1986 and found significant independent effects of social class, sex, and region of residence. The strong effect of social class shows the need to control for differences in social factors between populations of patients before concluding that one system of treatment is better than another and before making policy decisions on providing facilities. The regional differences provoke the question of why survival is so much better in some regions than others and what, if anything, can be done about it.

Microalbuminuria in diabetes and cardiovascular risk factors

Microalbuminuria in insulin dependent diabetics is a strong indicator of subsequent development of diabetic renal disease. Diabetics with renal disease have a greatly increased risk of death from cardiovascular complications. On page 487 Jones *et al* report the presence of altered concentrations of lipoproteins, increased concentrations of apolipoprotein B and fibrinogen, and increased arterial blood pressure in diabetics with microalbuminuria compared with matched controls with normal albumin excretion rates. The authors conclude that cardiovascular risk factors are present in diabetics with microalbuminuria before the onset of renal failure and that early intervention in such patients may reduce the risk of death from cardiovascular complications.

Transplants from living donors

Kidney transplant units throughout Britain are finding that the numbers of patients waiting for kidneys are growing but the supply of donor organs seems to have reached a plateau. One solution would be an increase in the use of relatives or possibly spouses as living donors. On p 490 Donnelly *et al* report the results of a survey of 32 transplant centres. This showed that the use of living donors varied widely, from not at all in some centres to 20% of transplants in the Merseyside area. Sixty per cent of transplant surgeons were in favour of more transplants from living donors.

Aspirin and warfarin and gastric bleeding

The search is still on for the optimum prophylactic treatment for patients at risk of developing symptomatic coronary heart disease. Among the candidates are low doses of aspirin and warfarin (or a combination of the two). Both drugs, however, may cause bleeding from the stomach, so as a first step this hazard needs to be measured. On p 493 Prichard *et al* report a study on the effects of aspirin (75 mg a day) or warfarin, or both, on gastric blood loss in young male volunteers. Aspirin doubled the rate of blood loss, whereas warfarin had no effect either alone or in combination with the aspirin.

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 7 January 1989, p 40.