This week in BMJ

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Secondary cases of meningococcal infection in England and Wales

Prophylaxis with rifampicin is recommended for close family and household contacts of patients with meningococcal infection. If untreated, close contacts are at greatest risk in the first week after diagnosis of the disease in an index patient. Yet despite early chemoprophylaxis secondary cases of meningococcal infection still occur. During a recent four year survey of such cases in England and Wales Cooke *et al* (p 555) found that the commonest time interval between the onset in the index and secondary cases was seven weeks, the longest interval being over nine months. The prophylactic measures taken after an index patient was identified were often suboptimal. Nevertheless, even when optimal chemoprophylaxis is given doctors should be aware that close family contacts are at prolonged and increased risk of developing secondary meningococcal infection.

Incidence of insulin dependent diabetes in England

The incidence of juvenile onset insulin dependent diabetes varies widely among countries, and there are suggestions that it is increasing. How English rates compare, and whether they are changing are not known with any certainty: large scale studies with adequate case ascertainment have not been done.

As part of the Barts-Oxford study of childhood diabetes Bingley and Gale (p 558) calculated the incidence of newly diagnosed insulin dependent diabetes in people under 21 living within the boundaries of the Oxford Regional Health Authority. Achieving a rate of case ascertainment greater than 95% in a population of 2·4 million their study provides a basis for comparison—both with other countries and with later periods.

Intrauterine growth and cardiovascular mortality

Differences in death rates from cardiovascular disease between one part of Britain and another match past differences in neonatal and maternal mortality, which suggests that risk of cardiovascular disease may be partly determined in utero. Now Barker *et al* (p 564) report an inverse relation between intrauterine growth, measured by birth weight, and blood pressure in national samples of 10 year olds and adults aged 36 followed up since birth. They also report that children living in areas with high cardiovascular mortality are shorter and have higher pulse rates than those living in other areas. The authors conclude that the intrauterine environment is important in determining the risk of cardiovascular disease and the differences in rates between one part of Britain and another.

Iloprost versus nifedipine in the treatment of Raynaud's phenomenon

Most vasodilatory drugs have been tried in patients with Raynaud's phenomenon, usually with disappointing results. On p 561 Rademaker *et al* compare the effects of iloprost, a stable analogue of epoprostenol, and nifedipine on Raynaud's phenomenon in patients with systemic sclerosis in a placebo controlled randomised trial. Infusions of iloprost were given at the beginning of the trial and again eight weeks later; oral nifedipine was given throughout the 16 weeks of the trial. Both drugs reduced the number, severity, and duration of attacks of Raynaud's phenomenon and the number of digital lesions. Iloprost but not nifedipine increased hand temperature and blood flow. Based on these findings the authors conclude that intermittent intravenous infusions of iloprost may be at least as useful as continuous oral nifedipine in controlling symptoms.

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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.