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Keratinocyte grafting and transplantation

Tissue culture techniques have advanced such that skin cells (keratinocytes) can be grown in the laboratory, giving a skin expansion method that increases the original area of a biopsy specimen by several thousand. Cultured keratinocytes have been used successfully as grafts in patients with burns and leg ulcers and in children with severe ulcerating skin disease, and it has been suggested that the culturing of skin cells overcomes transplant rejection. On pages 915 and 917 Burt *et al* and Brain *et al* show independently and unequivocally that cultured skin cells do not survive transplantation. Thus other biological effects, such as the production of growth factors, may explain the reported beneficial effects of cultured keratinocytes allografts.

Plasma cholesterol, coronary heart disease, and cancer

The debate over whether we should all eat a diet low in saturated fats or whether this advice should be limited to people with a raised plasma cholesterol concentration seems far from over. Helping to prolong the debate are the results of a study done in the west of Scotland by Isles and colleagues (p 920). Their main finding was that the overall mortality among 15 000 middle aged men and women was not related to plasma cholesterol concentrations. Although cholesterol concentrations and coronary heart disease were positively correlated, there was a negative relation between cholesterol and other causes of death, especially cancer. Because these relations persisted when patients with early cancer were excluded, the low cholesterol values recorded in the areas covered by the study (Renfrew and Paisley) were unlikely to have been a consequence of malignancy. Similar findings have been reported from other centres. Hence it may be a mistake to assume that dietary advice given to the general population to reduce the intake of saturated fat will necessarily reduce overall mortality. Isles *et al* conclude that until more is known of the mechanism underlying the negative association between cholesterol and cancer the wisest strategy for preventing coronary heart disease will be to concentrate on patients at highest risk.

Trying to predict the development of osteoporosis

The risk of developing osteoporosis depends on the maximum bone mass attained and the subsequent bone loss. If the occurrence of osteoporosis could be predicted preventive treatment could be given only to those at risk. On p 924 Stevenson *et al* report the results of a study of bone density, measured by dual photon absorptiometry, and lifestyle in 284 healthy women. They found that peak bone density was achieved by or soon after the end of linear skeletal growth. There was a gradual age related decline in bone density in the femoral neck and Ward's triangle but no appreciable loss of vertebral bone before the menopause. Alcohol had a deleterious effect on bone density in young women. Cigarette smoking had a significant negative effect on vertebral bone density. Exercise and calcium intake had no effect on bone density in premenopausal women, but exercise had a small positive effect in postmenopausal women. Bone density could not be predicted accurately from any combination of the factors, however, and direct measurement of bone density remains the best way to select women for preventive treatment.

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.

Tables and illustrations should be separate from the text of the paper. Tables should be simple and should not duplicate information in the text of the article.

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.