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Diagnosis of pneumococcal pneumonia in developing countries

Pneumococcal pneumonia causes millions of deaths in children under 5 years old in developing countries every year. A precise diagnosis still depends on traditional methods of detecting bacteria, such as culture of blood, which are insensitive and time consuming and require special laboratory facilities and skilled staff. On p 1061 O'Neill *et al* describe a latex agglutination test that detects fragments of the capsular polysaccharide of the pneumococcus excreted in the urine of infected children. A considerable improvement in sensitivity was achieved by coating the latex particles with antisera to single serotypes of pneumococcus rather than to all 83 serotypes. The test is cheap and easy to use and may be useful for investigating the epidemiology of pneumococcal disease in areas with limited laboratory facilities.

Age related incidence of AIDS in haemophiliacs

AIDS has been high on the research agenda for many years. Yet only recently have sufficient data accrued from cohorts of individuals with known or estimated dates of seroconversion to enable the relation between its latent period and other factors to be studied.

On p 1064 Darby *et al* present data on 1201 seropositive haemophiliacs among whom 85 cases of AIDS have been diagnosed. There is a clear increase in incidence of disease with increasing age, and by five years after seroconversion those aged over 45 have almost five times the risk of developing AIDS of those aged under 25. Other factors such as type and severity of haemophilia or the origin of the material that caused HIV infection had no significant effect on development of disease. Darby *et al* also present data on mortality of haemophiliacs positive for HIV who had not been reported as diagnosed with AIDS. Almost all the 13 deaths among those who had been reported as having "AIDS related complex" are likely to have been caused by HIV, although for only four of them did the death certificate mention HIV or conditions known to be associated with it.

Assessment of airflow obstruction in clinical practice

Measurement of peak expiratory flow (PEF) has become established as an invaluable test in the clinical management of diseases which give rise to airflow obstruction, notably asthma and chronic bronchitis. Nevertheless, for identifying the presence of airflow obstruction and assessing its severity the usefulness of the test has been limited by uncertainty about predicted values of PEF in elderly people, in whom it is important to distinguish airflow obstruction from other causes of dyspnoea. On p 1068 Nunn and Gregg report new equations for the regression of PEF on age and height, which they derived from a study of men and women aged 15-85 who had never smoked and who satisfied other strict criteria of normality. The authors used these equations in a subsidiary investigation (p 1071) of the effects of smoking on ventilatory function in subjects aged 55-85 who, apart from being smokers or ex-smokers, fulfilled all their other criteria of normality. Highly significant reductions in PEF were found in the current smokers and also in the ex-smokers of 20 or more cigarettes a day. The magnitude of the deficit in PEF, however, was much less than that which is characteristic of patients with dyspnoea due to chronic bronchitis, leading the authors to conclude that other factors besides smoking are responsible for the severe degree of irreversible airflow obstruction which occurs in that disease.

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.