This week in BMJ

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Ultrasonography and the fetal renal tract

Routine antenatal ultrasonography often now includes examining the fetal renal tract. How common are abnormalities? How accurately are they diagnosed? How useful is it to know of their presence? This week we publish three papers (and an editorial, p 1408) that address these questions and help to define the place of ultrasonographic screening of the fetal renal tract.

On page 1417 Greig *et al* assess the value of making the diagnosis in 62 fetuses in which ultrasonography between 14 weeks' gestation and term had suggested renal abnormalities. When they checked their diagnoses postnatally they found that they had correctly diagnosed 46 cases by antenatal ultrasonography. Fifteen pregnancies were terminated on the basis of the antenatal findings. Among the 44 babies born alive other clinical findings would have suggested abnormalities of the renal tract in 14. For the remaining 30 babies the authors believe that antenatal diagnosis was of definite value in eight, of probable value in 15, and of marginal value in seven.

Arthur *et al* (p 1418) review the outcome of 126 cases of fetal uropathy, most of them picked up by routine antenatal ultrasonography at 17-19 weeks' gestation. Bilateral renal abnormalities were seen in 54 fetuses. Thirteen pregnancies were terminated because antenatal findings were incompatible with long term survival, and 10 other babies with bilateral uropathy died either in the early neonatal period or during infancy. Serious additional congenital abnormalities were common in aborted fetuses and babies who died. Prognosis for the remaining babies with isolated abnormalities of the renal tract was thought to be good.

On page 1421 Livera *et al* report the results of a prospective study in which more than 6000 fetuses were screened at around 28 weeks' gestation. Ultrasonography suggested that 92 fetuses had abnormalities of the renal tract. Postnatal assessment confirmed the diagnosis in 42 babies, 23 of whom were thought to have benefited from early diagnosis. As well as a high rate of false positive diagnoses ultrasonography was found to have missed abnormalities of the renal tract in six cases after 18 months' follow up.

Arthritis in patients with leprosy

So florid are some manifestations and complications of leprosy that other, more subtle changes may have been ignored. On page 1423 Atkin *et al* describe a peripheral arthritis with radiological joint erosions in a group of patients with leprosy. The distribution of joints affected was similar to the pattern seen in rheumatoid arthritis. The arthritis responded to antileprosy treatment but not to conventional non-steroidal anti-inflammatory drugs. Recently rheumatoid arthritis has been linked to mycobacterial infection, and further study of the arthritis in patients with leprosy may provide insight into rheumatoid arthritis.

Soluble interleukin 2 receptor in atopic eczema

Atopic eczema is a common skin disease of unknown cause. An immunological pathogenesis has been suggested but has proved difficult to define. New methods are now available to measure immunological activation in vivo, and one such test, measurement of the serum concentration of soluble interleukin 2 receptor, has already been shown to correlate with disease activity in rheumatoid arthritis and other immune mediated diseases. Colver *et al* (p 1426) have used this test to study patients with atopic eczema. Concentrations of soluble interleukin 2 receptor were high during active disease and fell with successful treatment. The concentrations correlated significantly with clinical scores of disease activity. These results support the idea that cellular immunopathogenic mechanisms contribute to the disease. The authors suggest that this fairly simple enzyme linked immunosorbent assay (ELISA) could be useful in clinical management and in assessing the response to 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.

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.