This week in BMJ

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Preventing postmenopausal bone loss with salcatonin

Women lose bone mass after the menopause, which in some cases is followed by the development of osteoporosis. The bone loss can be prevented by oestrogen replacement therapy. Not all women, however, are candidates for this treatment, and alternative treatment regimens have been sought. Calcitonin inhibits bone resorption by a direct effect on the osteoclasts and has been given by injection for many years to treat metabolic diseases that affect bone, such as Paget's disease and malignant hypercalcaemia. A recently developed nasal spray for administering salmon calcitonin (salcatonin) has made the prospect of treating healthy postmenopausal women realistic. On p 477 Overgaard *et al* report that in healthy women two and a half to five years after the menopause 100 IU of salcatonin given intranasally each day stopped bone loss in the spine. Bone loss in the proximal and distal forearms and total skeleton, however, was unaffected. The authors suggest that this may reflect a selective effect of calcitonin on the trabecular bone of the spine. On the other hand, a dose of 100 IU of salcatonin may be too low to affect the cortical bone of the forearms.

Recovery after subarachnoid haemorrhage

Patients who have been discharged after a subarachnoid haemorrhage usually have poor concentration, fatigue, headaches, and fear of a recurrence. Few general practitioners have enough experience of the condition to be able to answer the many questions that patients and their relatives have about these symptoms. On p 485 McKenna *et al* present the findings of a follow up study of patients with subarachnoid haemorrhage. Seventy patients who had no neurological deficit showed cognitive dysfunction on testing early in their illness. By three months nearly all were functioning at their premorbid level, and by one year none showed any evidence of cognitive impairment. A year after the event the only typical symptom was tiredness, but this did not interfere with lifestyle. General practitioners should reassure patients who have had a subarachnoid haemorrhage that has not resulted in neurological deficit that their recovery should be excellent.

Antihypertensive effect of diet compared with drug treatment

The therapeutic response to the risks of treating mild hypertension with drugs has been to recommend nonpharmacological measures initially. On p 480 Berglund and her colleagues report a randomised study that compares the antihypertensive and metabolic effects of a nutritional programme with that of stepped care treatment with atenolol as first line drug in a group of slightly to moderately obese men with mild hypertension. The antihypertensive effect of the diet was less than that of drug treatment, whereas the changes in serum lipid levels favoured dietary treatment. As the sample was selected the results cannot be regarded as representative of the general population. They may, however, be applicable to well motivated patients in everyday clinical practice.

Energy expenditure in diabetic children

Patients with insulin dependent (type I) diabetes that is poorly controlled commonly lose weight and may show signs of wasting. Even patients whose diabetes is well controlled are commonly thin. A possible explanation for these observations comes from some laboratory research on volunteer children with diabetes reported on p 487. Müller *et al*, working in Hanover, measured the children's metabolic rates and energy expenditure at rest and in response to an intravenous infusion of adrenaline. Diabetic children responded to the adrenaline infusion with a threefold rise in energy consumption compared with controls. In normal daily activity such an increase in thermogenesis in response to intercurrent stress might increase their daily need for energy by as much as 10%.

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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.