This week in BMJ

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Angiotensin converting enzyme inhibition and diabetic nephropathy

Roughly 40% of all diabetics, whether insulin dependent or not, develop persistent albuminuria, a decline in their glomerular filtration rate, and raised blood pressure, which collectively make up the clinical syndrome of diabetic nephropathy. This complication is the main cause of the increased morbidity and mortality in insulin dependent diabetics. Diabetic nephropathy is the single most important cause of end stage renal disease in the Western World, accounting for over a quarter of all end stage renal diseases. Effective antihypertensive treatment is the only measure available to the doctor to reduce albuminuria and postpone renal insufficiency in diabetic nephropathy. On p 533 Parving and colleagues show that in normotensive patients with insulin dependent diabetes complicated by nephropathy early intervention with captopril can arrest or even reverse the progressive rise in albuminuria.

Predicting the risk of spontaneous abortion

Spontaneous abortion is the commonest complication of pregnancy. Despite this, our understanding of its causes and our ability to predict the risk of its occurrence or recurrence in the individual patient are poor. Regan *et al* (p 541) have examined prospectively the incidence of miscarriage in a provincial community and related the risk of abortion to obstetric history. Among 407 women they found that, though the overall risk of spontaneous abortion was 12%, in primigravidas it was only 5%—substantially less than the 24% among women in whom previous pregnancies had ended in abortion. Furthermore, the outcome of the last pregnancy influenced the outcome of the next; only 5% of women whose previous pregnancy had been successful aborted, whereas the incidence of loss of pregnancy among women whose last pregnancy had ended in abortion was 19%. The authors conclude that, as the outcome of a first pregnancy has profound consequences for all subsequent pregnancies, a knowledge of the patient's reproductive history is of prime importance in assessing her risk of spontaneous abortion.

Disturbances of insulin in men surviving myocardial infarction

The epidemic of coronary artery disease in British Asians cannot be explained by classical cardiovascular risk factors such as cholesterol concentration, smoking, hypertension, or diet. The concurrent finding of an increased incidence of diabetes in Asians has led to speculation that both conditions may be linked by a common pathological process. On p 537 Hughes *et al* examine the associations between insulin secretion, hepatic insulin extraction, and cardiovascular risk in survivors of myocardial infarction and healthy controls with particular reference to differences between British Asian and white men. Tissue resistance to the action of insulin, which gives rise to increased pancreatic secretion, may be an important risk factor for coronary artery disease in both ethnic groups.

Vision screening at 8 and 18 months

Screening for vision and eye defects in infants and young children is carried out by health visitors in most health districts in Britain. On p 545 Johnson *et al* report the results of a study in the Oxfordshire Health District, which showed that when the tests were applied to a high risk population they were unable to detect eye conditions unless the defect was apparent on direct inspection of the infant's eyes or visual behaviour. Although the risk of an eye defect in the high risk population was nearly three times greater than in the low risk population, only 15% of cases occurred in the high risk group. These findings are important in planning effective programmes for vision screening in preschool children.

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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.