This week in BMJ

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Long term follow up of childhood pyelonephritis

The long term outcome in children with focal renal scarring due to pyelonephritis has not been extensively studied. On p 703 Jacobson *et al* report the incidence of uraemia, hypertension, and toxaemia in pregnancy in 30 patients with non-obstructive focal renal scarring after childhood pyelonephritis first diagnosed 25-35 years ago. They measured renal haemodynamics, blood pressure control, and hormones regulating blood pressure in these patients and 13 controls. After a mean follow up of 27 (SD 6) years three patients had developed end stage renal disease, seven had hypertension, and two of 16 women had had toxaemia during pregnancy. Hypertension in this group of patients seemed to be renin dependent. The authors conclude that children with non-destructive renal scarring are at high risk of serious long term consequences and should be carefully followed up during adolescence and pregnancy.

Psychiatric patients in hostels for the homeless

The number of places found for chronic psychiatric patients in the community does not match the number of long stay beds that have been lost. Have all these patients become self sufficient now that they have been discharged? The evidence from the United States suggests not—many are left to wander the streets. Now Marshall (p 706), in a study of two hostels for the homeless in Oxford, has produced evidence that something similar is happening here. He found that a third of the residents of these two hostels were chronically and severely mentally disabled. Most of this group were former psychiatric patients and half, in behavioural terms, were comparable to the most severely disabled long stay patients. What were once hostels rehabilitating the alcoholic homeless are now soaking up large numbers of discharged but very disabled chronic psychiatric patients. In effect they are becoming new mini-institutions. Is this the way to organise community care? he asks.

Readmission rates from medical record linkage

Few measures of outcome can be derived from the information collected within the NHS, but one measure of potential value is readmission to hospital after discharge. Studies of readmission rates may be useful for other reasons, such as monitoring planned discharge and readmission policies and studying the use made of hospital care by patients with chronic, relapsing conditions. On p 709 Henderson *et al* report readmission rates in the area covered by the Oxford record linkage study during 1968-85. The rates of elective readmission increased appreciably in most specialties over time, probably reflecting a trend towards planned discharge and planned readmission. Emergency readmission rates also increased over this period, which was less expected and possibly due to pressure on resources and inappropriately short lengths of stay in some instances.

General practitioners' care of patients with HIV

Although several postal surveys of attitudes of British general practitioners to AIDS have been carried out, their value has been limited by the brief and highly structured format of the questionnaires and the low rate of response. On p 713 Michael King reports the findings of detailed interviews with 270 family doctors in London about management of the psychological and social problems of people with HIV infection. The results do not suggest that they are reluctant to care for such patients. Many doctors are counselling patients and testing for antibodies themselves. Doctors without patients with HIV infection were less ready to counsel and educate their patients in general about AIDS and associated risk behaviours.

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.

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.