This week in BMJ

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US second class postage paid at Rahway, NJ. Postmaster: send address changes to: BMJ, c/o Mercury Airfreight International Ltd Inc, 2323 Randolph Avenue, Avenel, NJ 07001, USA.
US (direct) subscription $164.

Published by the proprietors, the British Medical Association, Tavistock Square, London WC1H 9JR, Telephone 01 387 4499, and printed by Pulman Web Offset Ltd. Typesetting by Bedford Typesetters Ltd, Bedford. Registered as a newspaper.

Demand for neonatal intensive care

During the past 20 years neonatal intensive care has become established as a specialty. The service has developed in a slow and piecemeal fashion, often with wide variation in the facilities available among neighbouring health districts. Much of the lack of coordinated planning has been caused by the absence of data identifying the need for the service. Field *et al* (p 1305) have attempted to remedy matters by estimating the use of neonatal intensive care in the Trent health region. They collected detailed information on each of 852 infants admitted requiring intensive care as well as on the daily workload of the 17 baby units within the region. From these data they estimate the use of neonatal intensive care to be 1·1 cots per 1000 births. This is well below the number of intensive cots staffed and funded in the region and may represent the maximum capacity of the present service. It does, however, clearly mark the minimum number of cots that each authority should plan to provide. At present the Trent region provides intensive care to very few extremely low birthweight infants, and any change in this policy would require increased resources.

Neuropathological findings in haemophiliacs positive for HIV

There have been several indications that the natural history of HIV infection in haemophiliacs may take a different course from that in other groups at risk. On p 1312 Esiri *et al* report the neuropathological and pathological findings at necropsy in 11 haemophiliacs and 31 non-haemophiliacs (29 homosexual men); although all subjects were positive for HIV, AIDS was diagnosed before death in only four haemophiliacs but in all but one of the non-haemophiliacs. At necropsy the haemophiliacs showed evidence of fewer opportunistic infections of the nervous system, less multinucleated giant cell encephalopathy associated with HIV, and more intracranial haemorrhages than the non-haemophiliacs. Outside the nervous system, however, haemophiliacs showed a significantly higher prevalence of liver cirrhosis than non-haemophiliacs. These findings suggest that some haemophiliacs positive for HIV die before the full blown effects of HIV on the nervous system have developed. Supervening fatal intracranial haemorrhage accounts for some of these deaths, though whether HIV has a contributory role in its pathogenesis remains uncertain.

Needle aspiration of amoebic liver abscess

Should the treatment of amoebic liver abscesses include needle aspiration in addition to metronidazole? Sharma *et al* (p 1308) report the results of a randomised trial that compared treatment with metronidazole alone with metronidazole and needle aspiration. After one year of follow up there were no differences in the resolution of abscesses between the two groups. The authors conclude that routine needle aspiration of uncomplicated amoebic liver abscesses is unnecessary and antiamoebic treatment with metronidazole alone is adequate.

Microemboli after thrombolytic treatment in myocardial infarction

Complications of thrombolytic treatment usually arise from haemorrhage or reperfusion injury. On p 1310 Stafford *et al* describe seven cases in which disintegration of the clot after treatment with thrombolytic agents resulted in severe symptoms, which they believe to be caused by multiple emboli. They suggest that conditions associated with intravascular clot may contraindicate thrombolytic 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.

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.