This week in BMJ

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Patterns of disease activity in multiple sclerosis

Differences in the pattern of clinical activity in multiple sclerosis are clearly well recognised, and the mode of onset of the disease and the extent of disability vary. The explanation for this variation is poorly understood. Thompson *et al* (p 631) used magnetic resonance imaging to study three clinically distinct groups of patients with multiple sclerosis: patients with minimal disability (benign disease), patients who had developed progressive disability after a relapsing and remitting phase (secondary progressive disease), and patients who had had progressive disability from the onset of the disease (primary progressive disease). The results showed little correlation between the extent of abnormality found by magnetic resonance imaging and the degree of disability. Extensive abnormality was seen in patients with benign multiple sclerosis, much of which was clinically silent, and patients with primary progressive disease had the least abnormality despite considerable disability. Appreciable differences in the abnormalities seen in the patients with primary progressive and secondary progressive disease support the suggestion from clinical and immunogenetic studies that these two forms of progressive multiple sclerosis have important differences in pathogenesis.

Social influences on fibrinogen concentration in middle age men

Fibrinogen concentration is a known risk factor for cardiovascular disease and premature death and has also been implicated in the inverse relation between social class and coronary heart disease. On p 634 Rosengren *et al* investigate this relation further and the influence of other social factors previously found to be related to mortality (number of people in the household and scores of social activities and activities at home and outside the home) in 639 middle aged men in Gothenburg. Activity scores, the number of people in the household, and occupational class (class 1 being unskilled and semiskilled workers and class 5 professionals and executives in the Swedish system) were inversely related to fibrinogen concentration only in non-smokers. Multiple regression analyses showed, however, that smoking was independently associated with fibrinogen concentration, that the sum of all activities was inversely associated, and that occupational class and the number of people in the household were not independently associated. Rosengren *et al* conclude that psychosocial factors seem to influence fibrinogen concentration so as to increase the risk of cardiovascular disease and premature death.

Implications of inflammatory changes on cervical cytology

Previous studies have suggested that inflammatory changes on cervical cytology may be due to underlying premalignant disease, but little has been published regarding genital tract infections. Wilson *et al* (p 638) investigated women with inflammatory changes on cervical cytology for infections and abnormalities on colposcopy. One fifth of these women, who had been referred from general practice and family planning clinics, had one or more sexually transmitted infections. These infections were associated with being single, separated, or divorced; aged under 25; and using non-barrier contraception. There was also a strong correlation between isolation of a sexually transmitted infection and finding an abnormality on colposcopy; hence the younger women were more likely to have premalignant disease. This paper highlights the probability of the presence of a serious genital tract infection in addition to cervical premalignancy and may help clinicians to formulate policies on managing patients with such cytological abnormalities.

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 6 January 1990, p 38.