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Dietary sodium and potassium in childhood and primary hypertension

A considerable body of evidence exists about genetic, dietary, and environmental factors in relation to hypertension. On p 899 Geleijnse and colleagues add to these data with a unique longitudinal study in children aimed at assessing sodium and potassium intakes in relation to blood pressure regulation in early life. They studied a cohort of 233 children aged 5-17 and estimated their average intakes of sodium and potassium from at least six annual urine samples. The results showed that sodium intake was not associated with the rise in blood pressure that occurred with age. Nevertheless, there was a smaller increase in systolic pressure in children with a high potassium intake and a greater increase in systolic pressure in those with high urinary sodium to potassium ratios. On average the rise in systolic pressure among children with the highest potassium intake was half that among those with a comparatively low potassium intake. Neither sodium nor potassium was related to diastolic pressure. These findings are important evidence that dietary potassium and the sodium to potassium ratio may be relevant in the early pathogenesis of hypertension.

Weight gain and long term propranolol treatment

β Blockade affects thermogenesis, but long term blockade has not been shown to result in weight gain in humans. This may be because any changes in weight caused by long term drug treatment are obscured by the weight gain that occurs naturally with age. On p 902 Rössner *et al* analyse retrospectively data from the β blocker heart attack trial, in which nearly 4000 men and women were randomised soon after an acute myocardial infarction to treatment with propranolol or placebo for up to 40 months. At the first, second, and third annual follow up visits patients treated with propranolol had consistently gained more weight than those treated with placebo. Furthermore, this weight gain could not be explained in terms of differences in the use of diuretics and in the amount of physical activity or by sex and age.

Reducing proteinuria with enalapril

Effective antihypertensive treatment of patients with diabetic nephropathy is important as it reduces the rate of deterioration in kidney function and also mortality. In addition, both acute and long term pharmacological reduction of blood pressure reduces proteinuria. It is not known whether all antihypertensive drugs are equal in this respect. On p 904, Björck and colleagues report a randomised study that compares the antiproteinuric effect of the angiotensin converting enzyme inhibitor enalapril and the β_1 selective blocker metoprolol. In most patients, frusemide was also used. During equally effective blood pressure control in both groups the proteinuria fell to half the initial value in patients treated with enalapril but remained unchanged in the group given metoprolol. The authors suggest that this supports the theory of a renal protective effect of angiotensin converting enzyme inhibitors.

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 include the minimum requirements for manuscripts submitted for publication.

All material submitted for publication is assumed to be submitted exclusively to the *BMJ* unless the contrary is stated.

Manuscripts will be acknowledged; letters will not be unless a stamped addressed envelope is enclosed.

Papers will normally be refereed and may be statistically assessed before acceptance.

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.

Drugs should be given their approved names, not their proprietary names, and the source of any new or experimental preparations should be given.

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.

Tables and illustrations should be separate from the text of the paper. Tables should be simple and should not duplicate information in the text of the article.

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.