This week in BMJ

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Symptomatic carotid ischaemia

The risk to benefit ratio of carotid endarterectomy is currently being investigated in several large randomised trials in Europe and North America. Before carotid endarterectomy is performed the carotid bifurcation must be adequately imaged by intra-arterial contrast angiography, which carries about a 1% risk of causing a major stroke. The absolute risk of carotid angiography, and therefore carotid endarterectomy, may be reduced if patients with carotid stenosis are selected accurately for angiography, thus avoiding unnecessary angiography. On p 1485 Hankey and Warlow describe their experience of nearly 300 patients with symptomatically mild carotid ischaemic events who were considered suitable for carotid endarterectomy. Using the predictive value of a carotid bruit for various degrees of stenosis of the internal carotid artery, together with the cost estimates of duplex carotid ultrasonography and cerebral angiography, they analysed the costs and risks of various clinical and radiological strategies in assessing different degrees of carotid bifurcation disease. For whichever degree of carotid stenosis a surgeon may currently be willing to operate on, they have provided the safest and most cost effective way to identify these patients for carotid endarterectomy.

Human papilloma virus types in anogenital warts in children

Adult anogenital warts, usually regarded as sexually transmitted, nearly always contain human papillomavirus types 6 or 11. As these types are rarely found outside the anogenital region this association is usually taken to indicate that types 6 and 11 are venereally transmitted. In children anogenital warts cause concern because, by extrapolation from adults, they raise the possibility of sexual transmission. Indeed, it has been suggested that the presence of human papillomavirus type 6 or 11 may help to confirm sexual abuse. The few studies that have been done of anogenital warts in children have shown the presence of types 6 and 11. In contrast, Padel *et al* (p 1491) showed that in six out of 17 children the warts contained a skin papillomavirus type in circumstances that suggested non-sexual transmission. Among the remaining children genital wart virus type was found in 10, but suspicion or evidence of child abuse was present in only five, suggesting other routes such as perinatal transmission. The situation in children thus seems to be more complex than in adults, anogenital warts arising from both sexual and non-sexual transmission. Hand-genital contact may also be a form of sexual abuse, so typing alone cannot confirm or refute this diagnosis, though it may be helpful in conjunction with other clinical and social investigations.

Control of defecation in patients with spinal injuries by stimulation of sacral anterior nerve roots

Patients with spinal injuries who have had sacral anterior root stimulators implanted to aid urinary control often lose the ability to defecate reflexly, and intractable constipation is common among such patients. The nerves used for electromicturition are the same as those that supply the distal colon, anorectum, and anal sphincter, and MacDonagh *et al* (p 1494) report on 12 patients who had their sacral anterior root stimulators adjusted to vary anorectal and colonic pressures and thus facilitate defecation. Six patients were able to defecate using the stimulator alone. All patients reported spending less time defecating each week and being free from constipation.

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.

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.