This week in BMJ

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Case finding for high blood cholesterol concentration

Although case finding may identify people with high blood cholesterol concentration, this screening strategy may interfere with strategies designed to reduce average concentrations by changing everyone's diet. In an Australian study reported by Kinlay and Heller (p 1545) 552 (92%) adults who had their blood cholesterol concentration measured while attending their general practitioner returned a postal questionnaire three to four months later. Of the 125 patients found to have a high cholesterol concentration at the initial visit (>6·5 mmol/l), 93 reported changing their diet. Far fewer people with concentrations less than 6·5 mmol/l, however, reported changing their diet, and overall 333 (61%) respondents reported not doing so. Nearly half the sample (n=266) reported not changing their diet because their blood cholesterol reading was "all right." Adults without high cholesterol concentrations were also significantly more likely to recall their doctor saying that they did not need to lower their concentrations and significantly less likely to recall receiving dietary advice. Case finding evidently does not lead to all adults identified with high blood cholesterol concentrations reducing their risk of heart disease. Furthermore, this strategy has the potential to interfere with national strategies that aim at reducing everyone's risk of heart disease. Kinlay and Heller suggest a more selective approach to blood cholesterol testing and recommend advising on lifestyle regardless of the concentration.

Inhaled steroids and skin

High dose inhaled corticosteroids such as beclomethasone can often transform the patient with chronic severe asthma. As well as controlling symptoms, this treatment allows most patients to discontinue systemic steroids and hence avoid the dismal consequences of long term prednisolone. Or does it? Inhaled corticosteroids given in high doses can "spill over" from the lungs into the circulation and produce systemic effects such as adrenal suppression or increased bone resorption in some patients. On p 1548 Capewell *et al* suggest that dermal atrophy should now be added to the list. Compared with controls patients taking high dose inhaled corticosteroids more often had purpura (10/21 patients *v* 2/17), and the skin of these patients was significantly thinner. These skin changes, however, were less severe than those seen in patients taking long term prednisolone. They emphasise that high dose inhaled corticosteroids remain preferable to prednisolone for chronic severe asthma.

A randomised, controlled trial of surgery for glue ear

Almost 100 000 children undergo surgery for glue ear (secretory otitis media) each year in England and Wales. The effectiveness of the various procedures used, however, remains uncertain. Black *et al* (p 1551) report the results of a randomised, controlled trial in which the five principal methods of surgical management were assessed. They found that the hearing level in ears in which a grommet had been inserted improved more than that in other ears, irrespective of any accompanying adenoid surgery. This benefit, however, gradually disappeared over the 12 months after surgery. Adenoidectomy failed to produce a significant improvement in hearing, though it did restore abnormally functioning middle ears in half the cases. As judged by improvements in hearing, these results suggest that preoperative level of hearing is the single best predictor of a successful outcome of surgery. Deciding on an appropriate threshold for surgical intervention remains a problem, however. The decision depends on avoiding unnecessary operations, on the one hand, and failing to treat children who might benefit, on the other. The authors make explicit the implications of different policies.

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.