This week in BMJ

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The role of ABO blood group in the risk of ischaemic heart disease

The possibility of a link between ABO blood group and susceptibility to ischaemic heart disease has been raised in several studies. Blood group A has been found more often than expected in patients with myocardial infarction and blood group O more commonly in communities with a high mortality from ischaemic heart disease. It has also been suggested that blood group A might be linked with higher social class. On p 1679 Whincup *et al* present data from an eight year follow up of 7662 men taking part in the British regional heart study, a prospective study of middle aged men in 24 British towns, that confirm some of these associations. There was a small increased incidence of ischaemic heart disease associated with blood group A, possibly explained by an increased concentration of serum cholesterol associated with this group. There was, however, no association of blood group A with social class. The prevalence of blood group O was related to the incidence of ischaemic heart disease on a town basis but not in individual subjects. The impact of ABO blood group on individual susceptibility seems to be small, and geographical differences in the distribution of blood groups do not explain the variation in the occurrence of the disease across Britain.

Cognitive and functional competence after anaesthesia in patients aged over 60

A firmly held belief exists that when elderly people are discharged from hospital after an operation they never fully recover. Similarly, anaesthetists and surgeons commonly believe that if an elderly person is too frail to withstand general anaesthesia then regional anaesthesia is the answer. On p 1683 Jones *et al* report that both anaesthetic techniques result in a similar perioperative and postoperative course. They found that the anaesthetic technique did not detectably influence the long term mental function of elderly patients provided that scrupulous attention was paid to avoiding known risk factors such as hypotension, hypoxia, and hypocapnia. Even though there was no detectable change in cognitive function, several patients in both groups reported an alteration in memory and concentration.

Perceptions of pain relief after surgery

A high standard of postoperative care should guarantee safe and effective pain relief, but how much pain should we expect after a surgical operation? On p 1687 Kuhn *et al* report the results of a study of the pain experienced by patients who had undergone elective hysterectomy or cholecystectomy. Visual analogue scales showed that the average intensity of pain on the first postoperative day was perceived as 60% of the maximum, and 40% of patients later described the experience as very painful. Patients' expectations of pain relief were too low, and staff tended to underestimate the necessary level of analgesia, which was seldom reviewed, and to overestimate the risk of opioid dependence. The authors point to better education of staff and better communication with patients as the correct solutions.

Loop diathermy excision for outpatients with abnormal cervical smears

Currently used treatments for cervical intraepithelial neoplasia are expensive and time consuming. How effective is diathermy excision of the transformation zone, which is cheap, quick, and could be provided as an outpatient procedure at any hospital with a diathermy generator? On p 1690 Luesley *et al* report their experiences of treating 616 women with loop diathermy excision. Morbidity was low, and the rate of success compared favourably with that of other commonly used treatments such as cold coagulation and laser.

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.

SI units are used for scientific measurements, but blood pressure should continue to be expressed in mm Hg.

References must be in the Vancouver style and their accuracy checked before submission.

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.

Detailed instructions are given in the *BMJ* dated 6 January 1990, p 38.