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Lowering cholesterol concentrations and mortality

Several randomised primary prevention trials have now shown that reducing serum cholesterol concentrations by diet or drugs, or both, lowers the incidence of major coronary heart disease events (predominantly acute myocardial infarction). Such interventions have not, however, been shown to reduce all cause mortality, and—with one exception—available studies provide no evidence that lowering cholesterol concentrations specifically reduces mortality from coronary heart disease. On p 309 Muldoon *et al* analyse the outcomes of six randomised primary prevention trials to examine effects of cholesterol reduction on total mortality and on death attributable to coronary heart disease, cancer, and causes not related to illness, using meta-analytic techniques. They show that cholesterol lowering treatments tended to reduce mortality from coronary heart disease and that total mortality was not affected by treatment. Although no consistent relation was found between cholesterol reduction and mortality from cancer, the incidence of suicide and violent death increased significantly in groups receiving treatment to lower cholesterol relative to controls. The association between cholesterol reduction and death not related to illness warrants further investigation. Additionally, the failure of cholesterol lowering to affect overall survival justifies a more cautious appraisal of the probable benefits of reducing cholesterol concentrations in the general population.

Treatment of osteoporosis with human parathyroid peptide

Few studies have examined the effect of treatment on spinal bone density in patients with primary or postmenopausal osteoporosis. On p 314 Reeve *et al* describe an open study of one effect of parathyroid peptide 1-34 plus either an oestrogen or nandrolone decanoate and make observations on patients treated with moderate doses of sodium fluoride plus substantial calcium supplements. By using quantitative computed tomography the authors have shown for the first time that parathyroid hormone can substantially increase trabecular bone mass (by about 50% above baseline) in the lumbar vertebral bodies. No significant changes occurred in cortical or trabecular bone mass variables in the radius in either treatment group. Spinal integral bone mineral density was measured by dual photon absorptiometry and this suggested that parathyroid peptide affected only trabecular bone. Roughly half the therapeutic response in the group given sodium fluoride was attributable to trabecular bone. Because of the recently described failure of high doses of sodium fluoride to reduce fractures significantly despite large increases in spinal integral bone mineral density the authors recommend that the efficacy of parathyroid peptides against future fractures in spinal osteoporosis should be evaluated.

Management of isolated thyroid swellings using fine needle aspiration cytology

Fine needle aspiration cytology has become increasingly regarded as the diagnostic method of choice in thyroid swellings. On p 318 Cusick *et al* report the results of a six year prospective study of 395 patients, of whom 307 underwent surgical excision. The positive predictive value of a "malignant" diagnosis on cytology was 100%, but only 83% of 64 malignant isolated thyroid swellings with satisfactory aspirates were identified cytologically as either malignant or possibly neoplastic. Aspiration cytology was unsatisfactory in 3% of these swellings, and 17% were falsely classified as non-neoplastic. Satisfactory aspirates were obtained in 91% of 181 removed neoplastic lesions (malignant lesions or follicular adenomas), of which 76% were correctly identified as possibly neoplastic or malignant and 24% were false negatives. The overall accuracy for removed swellings, 69%, was low. Since the introduction of fine needle aspiration cytology they have performed 21% fewer operations for isolated thyroid swellings. The accuracy of aspiration cytology has been calculated in various ways in previous studies, and recalculation according to strict criteria showed the accuracy to be less than has been widely accepted.

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.