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Socioeconomic state in childhood and ischaemic heart disease in middle age

Although ischaemic heart disease generally presents itself clinically in middle age or later, it is likely that it represents a disease process occurring over several decades. For this reason it is important to identify early determinants of the risk of ischaemic heart disease. On p 1121 Kaplan and Salonen present data from a population of 42-60 year old men in eastern Finland suggesting that one of the early determinants of risk of ischaemic heart disease in adulthood may be low socioeconomic state in childhood. These findings add to the many reports that identify socioeconomic position as a major determinant of risk for many diseases. Thus, improving the socioeconomic state of children may help to lower their risk of heart disease when they become adults.

Sexual transmission of hepatitis C virus

In about one tenth of patients with hepatitis C virus infection the only identifiable source of infection is through heterosexual contact, but preliminary data are scarce. On p 1130 Tor and others report the prevalence of hepatitis C antibody in a cohort comprising intravenous drug misusers and their sexual partners and homosexual men. There was a high prevalence (73%) of the antibody in the drug misusers that was not related to the presence of markers for hepatitis B virus or HIV. The homosexual men had a low prevalence (16%) of hepatitis C antibody and again this was not related to the presence of hepatitis B virus or HIV. The heterosexual partners of the drug misusers had a low prevalence of hepatitis C antibody, suggesting that the rate of heterosexual transmission of the virus is low. Its prevalence in this case correlated with the presence of both hepatitis B virus and HIV.

Famine in southern Ethiopia 1985-6

Drought and succeeding famine affected the Arero and Borana provinces in southern Ethiopia during 1985-6. Lindtjörn found a 40% increase in crude mortality among children living in traditional and stable societies, but the severe consequences were observed primarily among children living in relief shelters (p 1123). Increased childhood mortality was also associated with high prevalence of malnutrition, life in the most arid areas, and the dry season. A long period of food aid was needed to normalise the nutritional state, especially for children living in relief shelters. The reasons why people move from their homes during periods of starvation are complex, but as food shortage is the main reason early intervention with food aid may prevent such migration and may thus reduce the severe consequences of a famine.

Long term survival after intensive care

Long term survival after critical illness is an important aspect of the effectiveness of intensive therapy, and expensive resources such as this need to be directed towards patients whose outlook is good. To this end, Ridley *et al* (p 1127) examined the survival of 513 critically ill patients treated in an intensive therapy unit and assessed the effect of age, severity of illness, and diagnostic category on outcome. Long term survival was significantly related to age and severity of illness at admission, outcome being poor in elderly patients and in those with more severe disease. Multivariate analysis showed that age and severity of illness had a significant effect in determining outcome. The effects of severity of illness and age may be combined to calculate risk scores to estimate the probability of death; such scores may prove useful in determining the appropriateness of intensive care management and may assist internal audit.

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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.