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Course of HIV-I infection

The ultimate risk of developing AIDS after infection with HIV-I is not known. On p 1183 Rutherford *et al* describe the long term consequences of HIV-I infection in a cohort of homosexual and bisexual men from San Francisco that originally was recruited for studies of the epidemiology and prevention of sexually transmitted hepatitis B and has been followed up since 1978. They found that the cumulative risk of AIDS 11·1 years after seroconversion to HIV-I was 54% and that the risk of any clinical manifestation of HIV-I 10-12 years after seroconversion was 81%. The study supports the need to continue efforts to both prevent HIV-I infection and to further develop treatments that will stall or slow the progression of HIV-I infection to AIDS.

Diagnosis of abdominal masses with percutaneous biopsy guided by ultrasound

In patients with abdominal masses the need to confirm or refute a diagnosis of malignancy is paramount. Percutaneous biopsy or fine needle aspiration cytology is often used to obtain a specimen of tissue for histological examination, so making diagnostic surgery unnecessary. These methods, however, may cause considerable complications or require specialist cytological skill, which is not widely available. On p 1188 Jaeger *et al* report using percutaneous biopsy under ultrasound guidance in 108 consecutive patients with abdominal masses. Malignancy was suspected in 84 patients before biopsy and was confirmed in 70, in 26 of whom confirmation of dissemination obviated the need for further investigation. In 10 patients biopsy showed a different primary tumour from that previously suspected, and in 12 it showed only a benign lesion. Among 24 patients considered to have benign disease biopsy showed an unexpected neoplasm in seven. Four false negative but no false positive diagnoses resulted. The authors conclude that the technique is a safe and accurate method of obtaining a histological diagnosis in patients with abdominal and retroperitoneal masses.

Workload and work patterns of junior doctors while on call

The plight of junior doctors who work in stressful conditions over long periods without sleep is a matter of concern in respect of both the quality of patient care and the educational potential to the doctors concerned. On p 1191 Turnbull *et al* report a study of the workload and work patterns of 12 junior doctors of all grades during their periods on call at University Hospital, Nottingham, during December 1989. Senior house officers and preregistration house officers spent on average about 43% of their on call periods working, yet less than half of the work entailed direct contact with patients. A large amount of time was spent in administrative tasks such as writing records and reports and using the telephone. Both senior house officers and preregistration house officers were frequently interrupted by bleeper calls. By comparison, registrars worked on average less than a fifth of their time on call, spent a larger proportion of their working time with patients, and had fewer interruptions. These findings, based mainly on self completed activity records, confirm other reports of some junior doctors working excessively long hours during their periods on call.

Causes of fatal childhood accidents involving head injury

Head injury is the commonest single cause of death in children aged over 1 year, accounting for 15% of all deaths in children aged 1 to 15 and a quarter of all deaths in those aged 5 to 15 years. Strategies for primary prevention require a knowledge of the causes of these injuries, but few data are available on the cause and the circumstances of fatal childhood accidents involving head injury in Britain. On p 1193 Sharples *et al* conducted a retrospective study on 255 children in Northern region who died with head injuries, which shows that most children who sustained fatal accidents involving head injury were playing at the time of the accident. Three quarters of them were injured in a road traffic accident, most as pedestrians. Most accidents occurred within one to two km of the child's home and between 3 pm and 9 pm. The mortality was significantly related to social deprivation. Sharples *et al* conclude that an appreciable reduction in childhood mortality might be achieved if children at play were protected from traffic, particularly in socially deprived areas.

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.

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.

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.