This week in BMJ

All communications to:
The Editor, *BMJ*

Editor
Richard Smith

Art department
Derek Virtue

Correspondence
Fiona Godlee

Editorials
Tony Delamothe

General office
Leslie Moore
Andrew Woodward

News and Medicopolitical digest
Linda Beecham
Trish Groves
Jane Smith

Obituaries
Liz Crossan

Papers
Stella Lowry

Papers secretary
Susan Minns

Reviews
Ruth Holland

Associate editors
Tessa Richards
Roger Robinson
Tony Smith

Registrar
Luisa Dillner

Technical editors
Jacqueline Annis
Diana Blair-Fish
Tony Camps-Linney
Margaret Cooter
Sharon Davies
Deborah Reece

Executive director
Geoffrey Burn

Group advertisement director
Bob Hayzen

Production director
Derek Parrott

International sales manager
Maurice Long

Books marketing manager
Neil Poppmacher

Advertisement sales
Andrew Allsop
Sue Bound
Euan Currer
Caroline Scott

US second class postage paid at Rahway, NJ. Postmaster: send address changes to: BMJ, c/o Mercury Airfreight International Ltd Inc, 2323 Randolph Avenue, Avenel, NJ 07001, USA.
US (direct) subscription $180.00.

Published by the proprietors, the British Medical Association, Tavistock Square, London WC1H 9JR, telephone 071 387 4499 (editorial fax 071 383 6418). Printed by BPCC Magazines (Milton Keynes) Ltd, Milton Keynes. Typesetting by Bedford Typesetters Ltd, Bedford. Registered as a newspaper.

Genetic diagnosis of malignant hyperthermia

Reliable diagnosis of susceptibility to the inherited muscle disorder malignant hyperthermia currently depends on an in vitro muscle contracture test, which is highly invasive and requires a substantial amount of muscle tissue. Recent genetic linkage studies by Healy *et al* showed that the gene for malignant hyperthermia maps to the q12-13·2 region of chromosome 19. Extending this study to a large Irish malignant hyperthermia pedigree, Healy *et al* (p 1225) show that the gene for this disorder is closely flanked by the DNA markers D19S9 and D19S16, and that for the first time these and other flanking DNA markers can be used to diagnose susceptibility to malignant hyperthermia in untested subjects in large known malignant hyperthermia families. Furthermore, accuracy of diagnosis is superior.

Cognitive and behavioural treatment for hypochondriasis

Patients with hypochondriasis take up much time in general practice and other medical settings. They are often reluctant to accept a psychiatric diagnosis and are thus difficult to treat. Unfortunately, reassurance from doctors about symptoms often makes the problem worse. On p 1229 Stern and Fernandez describe a pilot study of cognitive and behavioural treatment given under the guise of stress management. The nine group sessions reduced the number of visits patients made to a doctor and the time spent thinking about illness as well as improving anxiety and depression. These benefits seemed to have been maintained at six month follow up.

British hostages in the Gulf

British citizens were the largest group who were detained by Saddam Hussein before the Gulf war. Many lost nearly all their possessions and their livelihood, and their ordeals have not necessarily ended with their release. In response to a postal questionnaire sent by Easton and Turner (p 1232) nearly 400 former hostages described different effects on their physical and psychological health, and a substantial proportion reported changes in their family relationships. The authors make recommendations to help those still in need and advise all expatriates working in risk areas to insure against similar losses.

Coffee drinking and mild hypertension

Many patients have borderline or mild hypertension, and the hope that a simple dietary change might lower their blood pressure sufficiently so that drug treatment is not necessary has provoked much research. However, only a few non-drug treatments are generally accepted as being worth while. Since single doses of caffeine raise the blood pressure of both normal subjects and hypertensive patients reducing dietary caffeine could be a useful therapeutic manoeuvre. On p 1235 MacDonald *et al* report a crossover study of long term dietary caffeine and instant coffee intake in mildly hypertensive patients. They found that caffeine restriction was futile as a non-drug treatment and argue that hypertensive patients should no longer be advised to change to drinking decaffeinated coffee to lower their blood pressure.

H pylori and non-ulcer dyspepsia

There is little doubt that antral colonisation by *Helicobacter pylori* causes development and recurrence of peptic ulcer disease. Although the relation to non-ulcer dyspepsia is less clear, its close association with type B antral gastritis suggests an important aetiological role. In a prospective short term study Patchett *et al* (p 1238) examined the effect of eradication of *H pylori* and healing of antral gastritis on symptoms in 83 patients with non-ulcer dyspepsia and *H pylori* infection. Symptom scores improved similarly in patients with persistent *H pylori* infection after treatment and those in whom *H pylori* had been eradicated, and the improvement was also independent of improvement in antral gastritis histologically. Thus neither the presence of *H pylori* nor healing of antral gastritis seemed to be related to symptoms after treatment, findings that provide evidence against *H pylori* having an important aetiological role in non-ulcer dyspepsia.

Communicating results of necropsies

The usefulness of necropsies for audit of clinical care is impaired if their results are inadequately communicated to clinicians. On p 1244 Whitty *et al* describe a study to evaluate the adequacy of current systems for reporting results of necropsies to referring clinicians and general practitioners with a questionnaire survey in four districts in North East Thames region. They identified unsatisfactory delays in the dispatch of reports and frequent neglect in informing general practitioners and relatives and recommend that pathologists dispatch a report of the macroscopic findings immediately after a necropsy to both clinicians and general practitioners; relatives should also be routinely offered the opportunity to discuss the findings.

Booked admissions

The length of time that patients may wait for elective surgery is not the only problem with the waiting list system. The uncertainty over when they may be called for operation can be a major burden for those waiting for surgery. Frankel *et al* (p 1257) consider the barriers to replacing waiting lists with booked admissions systems. A questionnaire study of consultant surgeons found a high level of support for booking systems, with some 78% of surgeons having operated a booking system in the past, operating one now, or wishing to operate one in the future. This interest in booking systems was frustrated by the problems that stem from allowing elective surgery to compete with urgent surgery for the same facilities.