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What dose zidovudine for AIDS and advanced HIV infection?

Data exist on the efficacy of zidovudine in AIDS and HIV infection, but the choice of dose has been largely anecdotal. On p 13 the Nordic Medical Research Councils' HIV Therapy Group report a double blind, parallel group multicentre trial of 400 mg, 800 mg, and 1200 mg zidovudine daily in 474 patients with AIDS and advanced HIV infection. There was no difference in mortality between the groups either at 19 months or one year after the trial had ended. There was also no difference in time to a new AIDS event or death, average number of events per patient, decline in CD4+ cell counts, wellbeing, or Karnofsky score. Zidovudine had to be withdrawn, however, in over a quarter of the patients, mainly for side effects, and the incidences of anaemia and leucopenia, time to first dose reduction, and numbers of patients withdrawn were all dose related. The authors conclude that zidovudine should be limited to 400-600 mg daily.

Hospital-general practice prescribing

Concern has grown that hospitals are seeking to save money by shifting outpatient prescribing on to general practitioners, who may lack the clinical expertise or resources necessary to assume this responsibility. In two linked papers Wilkie *et al* (p 29) and Sibbald *et al* (p 31) investigate these problems systematically. In November 1990 they surveyed the current outpatient dispensing policies of 200 major acute hospitals in England and in January 1991 examined their impact on the work of 1207 general practitioners and 457 hospital consultants. The findings reported in the first paper showed that there was a trend towards greater restrictions on the quantities of drugs supplied by hospitals to outpatients. According to the opinions of general practitioners and consultants recorded in the second paper, this has served to shift clinical responsibility on to general practitioners, who are not always best able to assume such responsibility. The authors conclude that the quality of outpatient care may suffer without appropriate guidelines to govern prescribing at the hospital-general practice interface.

Blood glucose control and diabetic retinopathy

Much evidence exists linking hyperglycaemia with retinopathy, but most studies have followed patients for only a short time. On p 19 Brinchmann-Hansen *et al* show the beneficial impact of long term lowering of mean blood glucose on progression of diabetic retinopathy. They followed 45 insulin dependent diabetic patients for seven years and found that a mean glycated haemoglobin concentration above 10% was associated with increased risk of progression of retinopathy and below 8·7% with a diminished risk. Multiple regression analysis identified four independent variables as important for seven year outcome of retinopathy: glycated haemoglobin at the start of the study and the change from the start to the mean level through seven years; duration of diabetes, and the degree of retinopathy at baseline.

Urinary problems and psychiatric disorder

Up to half of women presenting with dysuria and frequency have no evidence of infection in midstream urine specimens. Symptoms in those women with the urethral syndrome are often attributed to psychological disturbance, but the evidence supporting this assumption is poor. Sumners *et al* (p 17) examined this issue using objective psychiatric measures and found that women with urinary tract infection and the urethral syndrome had similar levels of transient psychological disturbance which subsided when the urinary symptoms resolved. The urethral syndrome was associated with increased dysuria and nocturia. Women with this syndrome should be taken seriously by their doctors.

Blood pressure up to age 10

Some evidence exists that adults' blood pressure is determined in childhood. Most studies in children, however, have been small or cross sectional. The Brompton study measured blood pressure in a large cohort of children from birth to age 10 years. On p 23 de Swiet *et al* report that blood pressure rises rapidly in the first weeks of life and more slowly thereafter. As children grow older the strength of correlation with earlier blood pressure measurements and average maternal blood pressure increased, suggesting that children were more consistently occupying a specific part of the blood pressure distribution. Studies in children should help determine why some adults have hypertension and others do not.

Chemotherapy in advanced cancer

The success of systemic cytotoxic treatment in curing testicular cancer, acute lymphoblastic leukaemia, and Hodgkin's disease has encouraged the widespread use of chemotherapy for other common cancers, but decisions on using cytotoxic drugs to treat many cancers that are beyond hope of cure remain difficult. Rubens *et al* scrutinised the collective experience of doctors and nurses working in palliative care of advanced cancer; on p 35 they outline what is currently considered to be good clinical practice in the United Kingdom. They caution against uncritical use of chemotherapy and emphasise the importance of giving it selectively and only with adequate supportive care. Their guidelines should help health authorities and general practitioners in commissioning care for their patients, as well as acting as standards for medical audit.

GUIDELINES FOR PAPERS SUBMITTED TO THE *BMJ*

General points

- All material submitted for publication is assumed to be submitted exclusively to the *BMJ* unless the contrary is stated and should conform to the uniform requirements for manuscripts submitted to biomedical journals (the Vancouver style; *BMJ* 1991;**302**:338-41).
- All authors must give signed consent to publication.
- The editor retains the customary right to style and if necessary shorten material accepted for publication.
- Type all manuscripts (including letters and obituaries) in double spacing with 3 cm margins.
- Number the pages.
- Give the name and address of the author to whom correspondence and proofs should be sent.
- Do not use abbreviations.
- Express all scientific measurements (except blood pressure) in SI units.
- Keep one copy of the manuscript for reference.

Points specific to each section

PAPERS, GENERAL PRACTICE, EDUCATION & DEBATE

Papers report original research relevant to clinical medicine. They are usually up to 2000 words long with up to six tables or illustrations (short reports are up to 600 words with a maximum of one table or illustration and five references).

General Practice covers matters relevant to primary care.

Education & Debate includes reports (up to 2000 words) on the organisation or assessment of medical work and on sociological aspects of medicine or the organisation, financing, and staffing of health services.

- Give the authors' names and initials, their posts when they did the work, and one degree each.
- Papers and General Practice articles should conform to the conventional format of structured abstract (maximum 250 words), introduction, methods, results, discussion, and references.
- Include a paragraph (maximum 150 words) for the This Week in *BMJ* page.
- Send three copies (if the paper is rejected these will not be returned; after three months they will be shredded).
- Whenever possible give numbers of patients or subjects studied (not percentages alone).
- Any article may be submitted to outside peer review and assessment by the editorial committee as well as statistical assessment; this takes about eight weeks.
- Manuscripts are usually published within three months of the date of final acceptance.

LETTERS

- Should normally be a maximum of 400 words and 10 references.
- Must be signed by all the authors.
- Preference is given to those that take up points made in articles published in the journal.
- Authors do not receive proofs.

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- Should be a maximum of 400 words.
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MEDICINE AND THE MEDIA

- Authors should discuss a proposed contribution with one of the editors before submitting it.
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PERSONAL VIEW

- Should be a maximum of 1200 words.

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- Should normally be a maximum of 250 words.
- Authors should summarise the person's career in a separate paragraph and not repeat these details in the main text.
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Tables

- Should be on separate sheets of paper from the text.
- Should not duplicate information given in the text of the article.
- Whenever possible, when relevant, numbers of patients or subjects studied should be given (not percentages alone).
- If a table has been published previously written consent to republication must be obtained from the copyright holder (usually the publisher) and the author(s).

Figures

- Should be used only when data cannot be expressed clearly in any other way.
- Should not duplicate information given in the text of the article.
- The numerical data on which graphs, scattergrams, and histograms are based should be supplied.
- Whenever possible, when relevant, numbers of patients or subjects studied should be given (not percentages alone).
- Legends should be on separate sheets of paper from the text.
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LINE DRAWINGS

- Should be presented clearly to aid redrawing.

FIGURES THAT ARE NOT LINE DRAWINGS

- Should usually be glossy prints.
- Should be no larger than 30×21 cm (A4).
- Important areas should be indicated on an overlay.
- The top should be marked on the back.
- Photomicrographs should include an internal scale marker.
- Labelling should be on copies, not on the prints.
- Patients shown in photographs should have their identity concealed or give written consent to publication (*BMJ* 1991;**302**:1194).
- Staining techniques for photomicrographs should be stated in the legend.

References

- Should be numbered in the order in which they appear in the text.
- Should give the names and initials of all the authors (unless there are more than six, when the first six should be given followed by *et al*); the title of the article or chapter; *and* the title of the journal (abbreviated according to the style of Index Medicus), year of publication, volume number, and first and last page numbers *or* the names of any editors of the book, title of the book, place of publication, publisher, and year of publication, and first and last pages of the article.
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